The Canadian Hospital Association is the federation of hospital associations in Canada and the Canadian Medical Association in co-operation with the federal and provincial governments and voluntary non-profit organizations in the health field.

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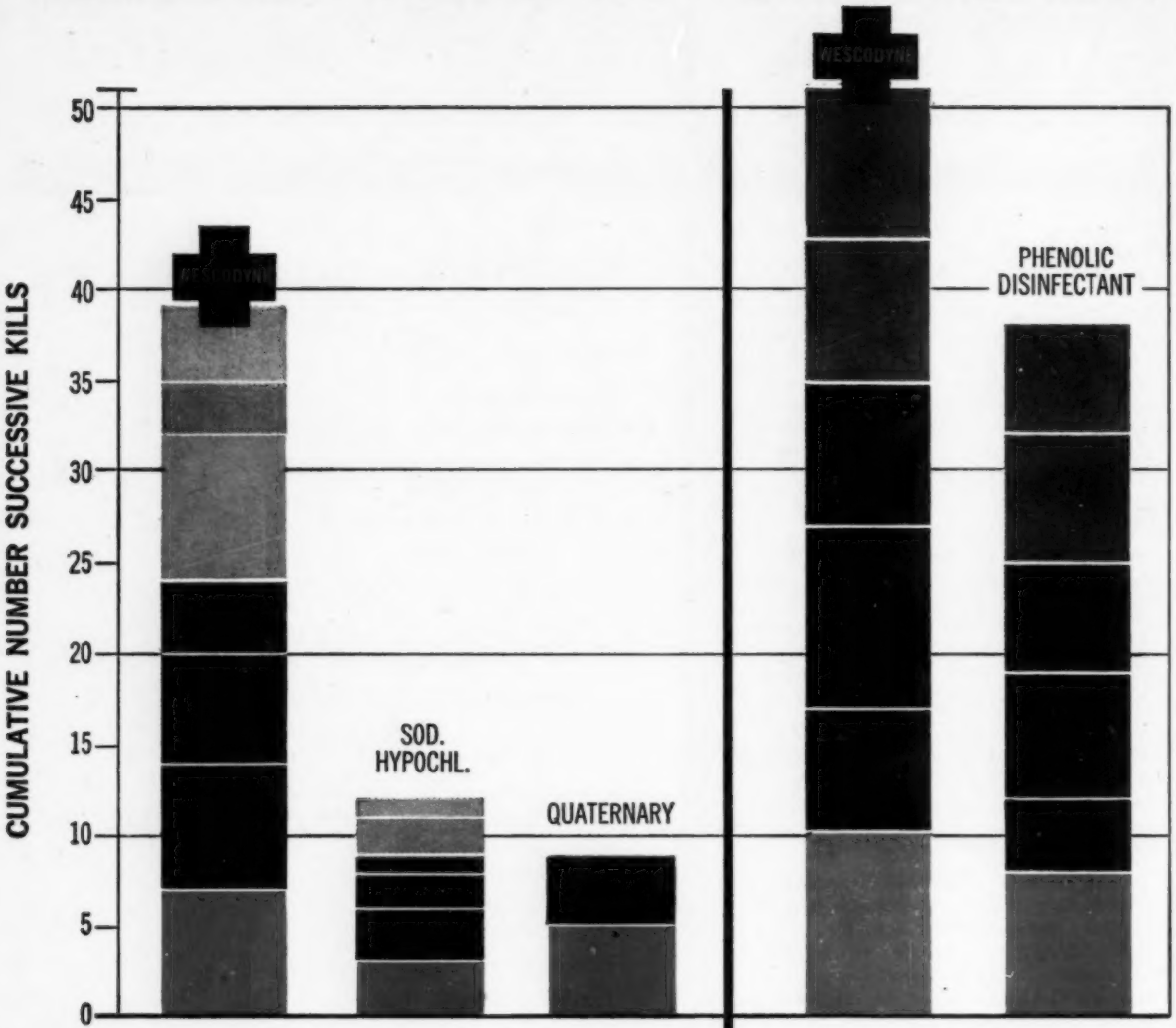
TESTS SHOW GREATER



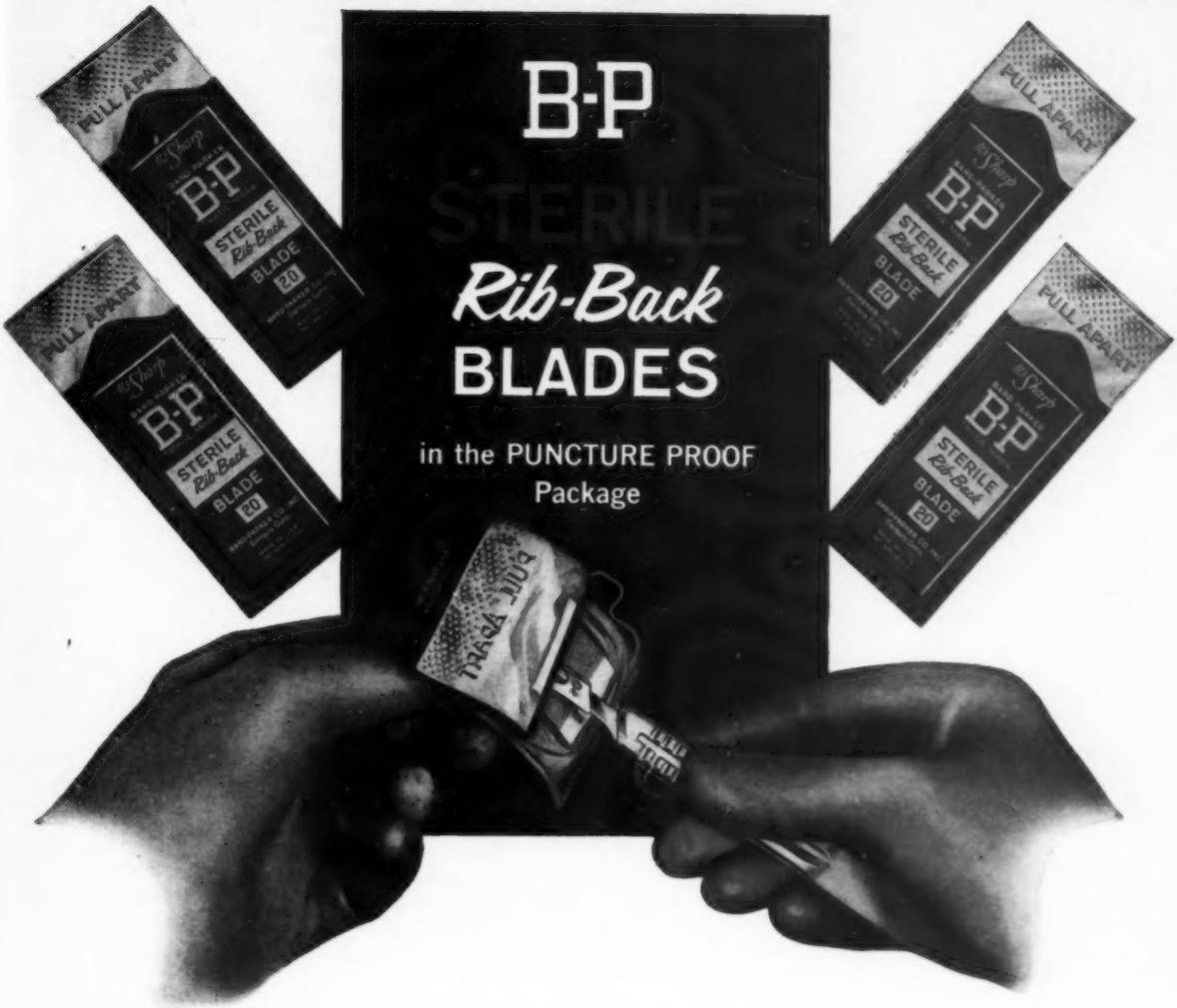
Capacity Test for Germicidal Action. (A. Cantor and H. Shelanski as described in Soap and Sanitary Chemicals, February 1951.) **Explanation:** This method essentially consists of adding to the use-dilution of the disinfectant or sanitizer, successive doses of a 50/50 mixture of milk plus broth culture of test organisms. These doses are added at ten minute intervals. Thirty seconds after each addition, a transfer is made into broth containing a suitable inactivator. This method makes it possible to determine the capacity of a germicide to kill before the micro-organisms and organic contamination have exhausted its germicidal action. **Organisms:** Salmonella typhosa, ATCC #6539; Micrococcus pyogenes. var. aureus, ATCC #6538; Salmonella pullorum, ATCC #9093; Pseudomonas aeruginosa, ATCC #8689; Trichophyton interdigitale Emmons 640, ATCC #9533; Penicillium luteum, ATCC #9644; Saccharomyces cerevisiae, ATCC #10274. **Dilutions:** WESCODYNE: 1:320 (50 ppm available iodine); Sodium hypochlorite: (100 ppm available chlorine); Quaternary: (50%) 1:5,000 (200 ppm active ingredient). **Temperature:** 15°C. **Media:** Fluid thioglycolate medium, USP XIII was used for testing WESCODYNE and sodium hypochlorite "Letheen" broth was used for testing alkyl dimethyl benzyl ammonium chloride.* All tests were re-subcultured in the same medium. **Results:** See above chart. **Conclusion:** The cumulative number of successful kills shows WESCODYNE to be over three times more effective than the nearest material tested.

*Neopeptone dextrose broth was used for testing the alkyl dimethyl benzyl ammonium chloride against the three fungi.

Wescodyne vs. Leading Phenolic Disinfectant. (A. Cantor and H. Shelanski Capacity Test as described in Soap and Sanitary Chemicals, February 1951.) The method used in this test is the same as that used in the Capacity Test for Germicidal Action described at left. **Dilutions:** WESCODYNE: 1:213 (75 ppm available iodine); phenolic disinfectant: 1:100 **Temperature:** 15°C. **Media:** Fluid thioglycolate medium, U.S.P. XIII was used for testing WESCODYNE and FDA nutrient broth was used for testing the phenolic disinfectant. All tests were re-subcultured in the same medium to eliminate bacteriostasis. **Results:** see above chart. **Conclusion:** This test shows that the bactericidal effectiveness (in the presence of organic contamination) of WESCODYNE at a dilution of 1:213 (75 ppm available iodine) is greater than that of a leading phenolic disinfectant at a dilution of 1:100.

PATHOGEN COLOR KEY:

- Salmonella typhosa (typhoid organism)
- M. pyogenes v. aureus (staphylococcus organism)
- Salmonella pullorum (poultry disease organism)
- Pseudomonas aeruginosa (wound contaminent organism)
- Trichophyton interdigitale (athlete's foot type of fungus organism)
- Penicillium luteum (mold organism)
- Saccharomyces cerevisiae (yeast organism)
- Strep. pyogenes hemolyticus (streptococcus organism)
- Escherichia coli (enteric organism)
- Shigella sonnei (dysentery organism)
- Salmonella schottmuelleri (food contaminent causing dysentery)



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Notes About People

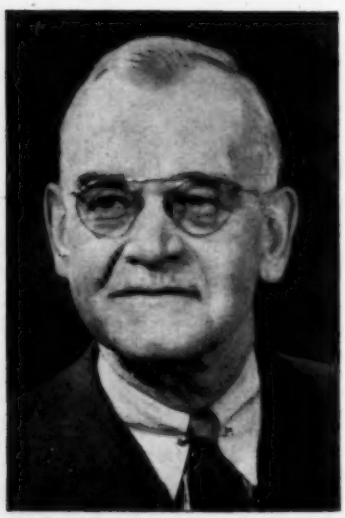
J. H. W. Bower

Joseph H. W. Bower, formerly superintendent of the Hospital for Sick Children, Toronto, Ont., died on December 2, 1958. He was in his 60's.

Born and educated in Toronto, Mr. Bower graduated from the University of Toronto in engineering in 1914, and in 1928, when the Hospital for Sick Children began planning a new building, he was chosen as superintendent to direct the program. The depression years and the second world war delayed the building, and in the meantime Mr. Bower managed to adapt the very old structure housing the hospital so that it could accommodate more patients and allow more research space than had been considered possible. His engineering skill manifested itself when, during the poliomyelitis epidemic in 1937, he designed an iron lung to overcome the shortage of respirators. Thirty of these machines were turned out in six weeks with the help of staff members who worked in relays. The "lungs" were shipped all over the province and later were adapted and produced commercially.

After the war the building program got underway to culminate in the new structure which opened in 1951. In September 1957 Mr. Bower retired, after 29 years of service to The Hospital for Sick Children.

He had been a member of the board of directors of the Ontario Hospital Association for nearly 20 years, and was president in 1944-45. He had also served on the board of management of the O.H.A.'s Blue Cross Plan, being chairman for a two-year term.



Joseph H. W. Bower

Medical Director at Misericordia, Edmonton

Dr. G. R. Macdonald, assistant professor of pathology at University of Alberta's faculty of medicine, has been appointed medical director of the Misericordia Hospital, Edmonton, Alta. Dr. Macdonald, a graduate of the University of Alberta, is from Red Deer, and practised at Fairview, Alta., before taking post-graduate work in pathology at the Universities of Alberta and Toronto. In 1951 he was made assistant provincial pathologist in Alberta and, at the same time, assistant pathologist at the University Hospital in Edmonton. In 1952 he became director of the laboratory medicine department at Misericordia. He is a certified specialist in pathology, a fellow of the College of American Pathologists, the Society of Clinical Pathologists and of the Royal Society of Medicine.

Moved to N.B.

Dr. Lynn E. Bashow has been appointed director of the new Forest Hill Rehabilitation Centre, Fredericton, N.B. Dr. Bashow, who graduated from Dalhousie University, Halifax, N.S., in 1943, was formerly on the staff of Lyndhurst Lodge, Toronto, Ont., and voluntary assistant in the department of physical medicine at the Toronto General Hospital.

Chesley Has New Superintendent

Appointed superintendent of the Chesley and District Memorial Hospital, Chesley, Ont., is Mary D. McQuiggin of Tillsonburg, Ont. Mrs. McQuiggin graduated from the Sarnia General Hospital in 1950 and has been with the Tillsonburg Memorial Hospital since then, serving as supervisor in all departments, as assistant director of nursing and for several months as acting director of nursing. She succeeds Marjorie Hawkins who came from Pembroke in 1955 to be superintendent at the Chesley hospital.

C. E. Barton Appointed to Regina Post

New executive director of the Regina General Hospital, Regina, Sask., is C. E. Barton who succeeds Dr. H. E. Appleyard in this post. Mr. Barton has been assistant superintendent since 1947, and is a member of A.C.H.A., president of the Saskatchewan Hospital Association, and chairman of the recently formed Western Canada Hospital Council.

Changes at Ingersoll

E. W. Roeder, formerly administrator at Alexandra Hospital, Ingersoll, Ont., has now taken a similar position at the York County Hospital in Newmarket, Ont. He is a graduate of the University of Toronto's course in hospital administration.

Succeeding him at the Alexandra Hospital will be Peter Breel, who comes from Chatham Public Hospital.

At the same hospital, Eileen Shaw, formerly with Kitimat Hospital, B.C., will be the new director of nurses.

Joins Winnipeg General

Dorothy Dick has been made clinical co-ordinator of nursing at the Winnipeg General Hospital, Winnipeg, Man. Miss Dick, who is a graduate of the Royal Victoria Hospital, Montreal, obtained her certificate in public health nursing from the McGill School of Graduate Nurses in 1942, and a B.Sc. from Columbia in 1948.

She worked with the Winnipeg Health Department for five years, and for the past nine years has been an instructor in the School of Nursing Education at the University of Manitoba. At the Winnipeg General she will direct educational programs for the graduate nursing staff and the orderlies of the hospital.

Joins Brant Sanatorium

Dr. Katherine E. Richter will take charge of the chest clinic work at the Brant Sanatorium, Brantford, Ont. Dr. Richter, who graduated from the University of Berlin Medical School, interned in various Berlin hospitals as well as

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People

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at the American Station Hospital there, specializing in paediatrics and anaesthesia.

She came to Canada in 1953 and, after passing examinations here, was appointed senior intern in medicine at the University Hospital, Saskatoon, Sask., and did general practice in Coranach, Sask., and Cooksville and Port Colborne, Ont. She succeeds Dr. Cyril Popov who resigned from the Brantford post.

New Medical Director

Dr. Jean-Louis Taillon has been appointed medical director of Hôtel-Dieu de St-Jerome, St-Jerome, Que. Dr. Taillon graduated with his medical degree from the University of Montreal in 1948 and has taken graduate courses at Hotel Dieu and Hôpital Notre Dame in Montreal, before practising in St-Jerome.

Scotsman in Milton Post

Don McCallum from Paisley, Scotland, is now administrator to the Milton District Hospital, Milton, Ont. which is under construction. Mr. McCallum, who came to Canada in 1949, was formerly administrator at the New Liskeard and District Hospital, New Liskeard, Ont., and has been office manager and accountant at the Welland County General Hospital in Welland, Ont., and office manager at the Greater Niagara General in Niagara Falls, Ont.

Rev. J. J. Schulz

The Reverend Jacob J. Schulz, founder and administrator of the Concordia Hospital, Winnipeg, and of the Bethania Home for the Aged in Parkdale, Man., died on Monday, December 1, 1958. He was 67.

Mr. Schulz, who was born in Russia, came to Canada 33 years ago, and was ordained in the Mennonite church in 1936. He was also a member of the Greater Winnipeg Regional Hospital Council.

• Sister Marie-de-Loyola has been made superior of l'Hôtel-Dieu de l'Assomption at Moncton, N.B. She has been director of nursing services at St. Paul Hospital, Vancouver, B.C., since 1955, and has

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Plunging In

In our December issue (page 43), we announced the holding of several institutes, jointly sponsored by various hospital associations and the national organization. The first one on housekeeping is being held this month in Winnipeg, and will be followed by a similar institute in Regina. Running concurrently with it will be an institute on labour relations. Similar programs are scheduled for Alberta and British Columbia in March.

We hope that administrators in the areas concerned will encourage their key personnel to attend. We believe the expense in attending institutes is small in comparison with the return—increased awareness, knowledge and efficiency. Let's all take the plunge.—*Edit.*


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People

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also served as administrator at Notre Dame Hospital, North Battleford, Sask., and as superior at the Hôpital Sacré-Coeur at Cartierville, Que.

● Dr. Carl Tupper of Halifax, N.S., has been appointed professor of obstetrics and gynaecology at Dalhousie University and head of the department of gynaecology at the Victoria General Hospital, Halifax. Dr. Tupper succeeds Dr. H. B. Atlee, who has recently been appointed professor emeritus.

● Willis F. Thompson, formerly personnel manager at the Civic Hospital in Peterborough, Ont., has been appointed administrator at Kirkland and District Hospital, Kirkland Lake, Ont. He had been with the Peterborough hospital for seven years.

● Anna O'Brien has been transferred from the staff of St. John's (Nfld.) General Hospital to help establish a new service to be given by the Newfoundland Department of Health. She is to be consulting dietitian to the 18 cottage hospitals there.

● Helen Hughes, director of nurses at the Cobourg District General Hospital, Cobourg, Ont., has been appointed superintendent of nurses at the Uxbridge (Ont.) Cottage Hospital. She is succeeded at Cobourg by E. McKenzie.

● Appointed director of Royal Victoria Hospital's speech and audiology clinics, Montreal, Que., is Earl R. Harford, Ph.D. With a B.S. degree from Florida State University, an M.S. from Vanderbilt, and a Ph.D. from Northwestern, he has had considerable experience as a speech and hearing consultant, both in practice and research.

● Dr. William A. Cochrane has been appointed associate professor of paediatrics and associate physician in the Children's Hospital, Halifax, N.S., on a full-time basis. He was formerly with the Hospital for Sick Children, Toronto, the Cincinnati Children's Hospital, Great Ormond Street Children's Hospital, London, England, and with the Toronto East General Hospital in Toronto, Ontario.

● The first full-time post in pathology at the Children's Hospital, Halifax, N.S., established this year, will be held by Dr. Kurt Aterman, a graduate of Charles University, Prague, and Queens University, Belfast.

A.C.H.A. Plans 2nd Annual Congress

From February 5 to 7, 1959, the American College of Hospital Administrators will hold its second annual congress on administration. The place is Hotel Sherman in Chicago, and on the agenda will be guest speakers, and 20 management seminars, as well as four general assemblies. The Administrator's Award, a $500 prize for the author of an outstanding book on the science of administration, will be given, and the author of an outstanding article on the administrative process, published in one of the seven major publications which serve the hospital field, will also be selected. Ten of the subjects that proved popular at the first congress will be repeated.

W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

Making 1959 a successful year

MANY administrators are so busy with day to day routine that they do not take enough time for constructive thought. Administration involves planning—planning with clear thought. Because much of our success depends on our basic philosophy, we need to take time to review our own attitudes. We must have positive ideals and objectives. In the daily hustle and bustle we must not forget the purpose for which we are working—care of the patient.

Working with the administrator to achieve good patient care is a relatively large and varied staff. To give adequate service to the patient, he must rely on his staff; hence he must give them due consideration in all planning. Too often we are more concerned with blue prints and the equipment than with the human beings who will give the service, and the conditions under which they will work. For example, in the architectural planning of any area, he should ask the opinions of the people who are going to work there. It is a fallacy for any administrator to believe that he and an architect alone, no matter how competent both may be, can know *all* the intricacies of ward or department lay-out. They can always benefit by constructive criticism and suggestions from supervisors, head nurses, and others who will manage specific areas.

Of course, all planning does not relate merely to construction. Continuous planning is necessary for successful everyday operation. There must be new ideas and constant review of existing conditions. An old proverb states that two heads are better than one, so it is a sound administrative principle to encourage all staff to bring new ideas forward.

Planning is futile as long as it exists merely in our heads or on paper. This brings us to the next step, that of organizing. Some administrators seem to be innately creative; they appear to grab ideas out of thin air! Once they have the idea, however, many fail to translate it into action. For success all new ideas must be crystallized into a detailed organizational pattern. In some instances we fail because we find it difficult to delegate responsibility, because we want to hold all the reins in our own hands. This is not possible in a hospital. We must be able and willing to communicate our ideas to subordinates. A frequent complaint heard around a hospital is, "Nobody ever tells me anything". This remark is not limited to the rank and file of hospital personnel — it is often expressed by department heads. One cannot expect department heads on their own to have the same over-all picture of hospital operation seen by the administrator. Therefore we must pass on to them the picture as we see it.

Some administrators believe their job is done when they have taken time to plan, organize and deputize. But this is only the beginning—it is essential that they must scrutinize the results. Too many administrators fail in this because they have not thought out what basic information they themselves require to control the organization. One cannot exercise sound judgment without having adequate statistics and other pertinent facts. Each administrator must decide for himself, depending on the size of his hospital and its complexity, just what facts he needs, and how often these should be reviewed. Of course there must be at least a budget, a monthly financial statement, a daily census, and information on the occupancy rate and the proportion of personnel to patients.

Control surely involves observing what is going on and comparing the results with some standard. We first have to see what is going on and, if necessary, do something about it. In order to know what to do we must make comparisons between what is going on now and what happened in the same period last year in our own and similar institutions.

Many administrators shy away from comparisons of staff efficiency because they believe it difficult to find reliable, readily comparable indices of staff efficiency. Industry, however, has long since solved this problem and much of industrial management know-how is applicable to hospitals.

A comparison of salary schedules is a favourite with many hospital administrators. This is understandable because salaries form such an important part of the total hospital budget. In a country like Canada, however, with its regional economic differences, there is not too much to be gained in comparing the salaries of any one group of hospital personnel with, say, those of Halifax or Vancouver. Much more important is the comparison of salary scales of various categories with similar categories in your own community. Much of the over-all hospital operation can be broken down into component parts, and much of our operation is similar to industrial activity found in the community. It is not too difficult to obtain standards which have long since become acceptable in industry for, say, the area of wall a person can wash or paint in a given time, for the area a floor polisher should cover in an hour, for the cost of combustion of a given quantity of fuel, and so forth.

There is one inherent danger in control if management restricts its attention only to things that can be measured readily. For instance, even if two hospitals are comparable, the one that has the shortest days stay may not necessarily be giving the best patient care. Patients are not packages and cannot be routed through a hospital on an assembly line basis.

Some administrators bend over so far backwards in surrounding themselves with controls, which they gain through a variety of statistical and other reports that they believe these alone give them the over-all picture of what is happening. While the forming of administrative judgments on insufficient information is to be deplored, the swamping of one's desk with statistics, charts, and reports in a quantity beyond digestion, is equally as bad. Such an administrator will view his organization from his inner sanctum and believe he really knows his hospital. Figures and charts are a means to an end, but not an end in themselves. As he is dealing with a living organization, the administrator must feel its pulse by taking time to know it personally. For example, a morning spent seated behind the switchboard operators, or an unannounced visit and quiet inspection of various departments can be most informative. Nor is the job complete unless he walks through his institution, from time to time, at the dead of night—because the pulse of the hospital at the bustle of midday and at 2.00 a.m. is quite different.

Make these your resolves for 1959: take time to think clearly; translate planning into improving your organization; increase your means of communication with staff; deputize, wherever possible; and follow through with an adequate survey of the results achieved. Then, as the year draws to a close, you should be able to look back and experience the personal satisfaction of knowing you have done a good job.

In Search of Staff

"IN ALMOST every province there is excited talk about convalescent hospitals and nursing homes and yet clearly there is no staff in sight to meet these new demands." So writes a worried administrator. At first glance, his fears are easily understood. Even though hospital construction costs from 1954-57 totalled $520,000,000, there is still a need for more nursing homes and/or more facilities for long-term care. And, with an increasing proportion of aged people in the population, the need will certainly grow.

It is natural, then, to ask—"Where will we find the staff?" In looking around, we can see for one thing that recruitment and training programs must be stepped up and pepped up. The present concern about high personnel turnover shows us that there are many people willing to try hospital work. They must be persuaded to stick with it. Salary schedules more comparable to those in industry, improved working conditions, a shorter work week—all these factors can stabilize staff. And they are within every hospital's grasp.

Looking farther afield, we see possible new staff sources. For some years there has been an increasing enrollment in our nursing schools, and many administrators are looking forward hopefully to the sixties when much larger classes graduating from high schools are forecast. These large classes are bound to continue, since Canada is an expanding country. Here the benefits of more strongly appealing recruitment programs would be obvious!

In our search, we must focus on the development of a comparatively new group of hospital workers —the nursing assistants. They have proved their worth in general and special hospitals, and where it counts, in chronic and nursing home care. The future development of this nursing position augers well, not only because it requires less formal training and therefore appeals to a larger number, but because it offers a fine opportunity to the mature woman who wants to work. In this age, married and older women are a great potential working force. If you doubt this, look at your graduate nurses. Older women are ideal for nursing jobs in convalescent and chronic hospitals. Often they have a depth of sympathy lacking in younger women who have not seen quite so much of life. If they can reach the patients with that sympathy, if they can offer them the kindness and understanding that accompanies experience in living, then they will be doing a good job.

Then, too, we must not overlook the results of Canada's immigration policy. People come to Canada eager for employment, eager for the chance of contributing their skills to their newly-adopted country. Without a doubt many of them, particularly those from health-conscious states, are assets to Canadian hospitals.

With these staff sources within our immediate range of vision, the reasons are clear why we must strengthen our training programs, improve our recruitment campaigns, and make our hospitals better places in which to work. All these people *can* become efficient hospital workers—if we rise to the task that faces us. Then we can be sure of one thing—where there is a need, that need will be met.

Hospital Plans in Western Canada

B.C.H.I.S. — responsibilities

Donald M. Cox,
Victoria, B.C.

THE fact that the structure of province-wide hospital insurance coverage was developed in Western Canada and the entry of the four western provinces into the federal-provincial program as soon as possible is evidence that the pioneering spirit of the West is still very real and dynamic. The people of British Columbia have long been interested in health and hospital insurance. A Royal Commission on state health insurance was appointed in 1919. In 1936 a Health Insurance Act was approved and a Health Insurance Commission was established. No real progress was made until 1948 when the Hospital Insurance Act was passed. It was at the insistent demand of hospitals and the public that the Hospital Insurance Service was established. By 1947 quite a number of hospitals were in desperate financial straits, with as high as one-third of their accounts uncollectable. Cities and municipalities often had to provide large grants to keep the hospitals going. Many people delayed needed treatment because they were not able to pay hospital bills.

The B.C. Hospital Insurance Service began operation on January 1, 1949. The Service was established on a premium basis with premiums of $15.00 per person, $24.00 for a man and his wife, and $30.00 per family. Various premium advances were needed as hospital costs rapidly increased. These increases were occasioned by:

1. A larger number of hospital admissions, resulting from a backlog of elective conditions whose treatment had been delayed for fear of the cost. In some cases also there were unnecessary demands for hospitalization.

2. A demand in many areas for better and more complete hospital services than could previously have been afforded.

3. An increasing insistence by hospital employees for wage increases and other concessions.

4. Rising cost of living, apparently stabilized at the time the plan commenced, but rapidly spiralling as a result of the international situation.

5. A steadily expanding population calling for greatly increased hospital accommodation.

Premiums eventually reached a high of $30 per single person and $42 per family, with a scale of co-insurance charges to the patient from $2.00 to $3.50 per day up to a limit of 10 days per family per year. The rates were later reduced to $27.00 for a single person and $39.00 per family, with a charge of $1.00 a day to the patient.

Because of its great primary industries and ample employment opportunities, British Columbia finds some 20 per cent of its working population continually on the move. In addition, because of its gentle climate, the coastal region attracts many elderly people, often with limited incomes. As a result, no premium plan could be devised to ensure full coverage of British Columbia residents, and I question whether any personal premium plan anywhere can achieve universal coverage. About eight per cent of hospital admissions were non-insured residents who had failed to keep up coverage. In some areas there were few non-insured and in others a good many.

Effective April 1, 1954, the legislature amended the Hospital Insurance Act, eliminating direct collection of premiums and providing for financing the Service from consolidated revenue. At the same time the provincial social services tax (retail sales tax) was increased from three per cent to five per cent. The net result was the immediate coverage of every resident, a situation never previously achieved on this continent. The staff of the Hospital Insurance Service was reduced from more than 450 to just under 100, and administration costs were reduced by $1,200,000. But we

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The author, who is commissioner of the B.C. Hospital Insurance Service, gave this address at the 13th Western Canada Institute, September 1958.

must remember that there are geographic and employment differences.

The Hospital Insurance Service functions as a branch of the Department of Health and Welfare and is administered by the Commissioner, with the status of a deputy minister.

In addition to the work of the Hospital Insurance Service, the staff administers the Hospital Act, which includes regular inspections and review of the operation of all general hospitals and nursing homes, or private hospitals as they are designated in British Columbia. The staff also handles the program of grants-in-aid for hospital construction and equipment. The scale of grants is the most generous in Canada, being 50 per cent of the cost of approved construction projects, one-third grants for renovations, and one-third for purchase of furniture and equipment. There are seven administrative divisions of the Service which function as a team, with line officers of one division frequently serving as staff officers to another.

Benefits

1. Generally speaking, all permanent residents, after being three months in British Columbia, are entitled to hospital benefits.

2. Payment of hospital accounts covers acute hospital care. This includes the acute phase of chronic illness.

3. Benefits are broad—standard ward accommodation, including laboratory, x-ray and other diagnostic services, the use of the operating room, case room, almost all drugs and dressings, and in fact, pretty well all services that are provided by the hospital.

4. The patient is required to pay $1.00 per day (except for welfare recipients and newborn infants).

5. In addition to in-patient care, the use of out-patient hospital facilities required within 24 hours of an accident, or for minor surgery, are provided as benefits —the patient being required to pay a nominal sum of $2.00.

6. The residents of British Columbia are entitled to hospital insurance benefits if hospitalized outside the province, with certain limitations.

Payments to hospitals are on a firm budget basis. Hospitals are asked to submit by the end of the year estimates of operating costs and occupancy for the next year. These estimates are checked intensively by the accounting staff and comparisons are drawn with each hospital's previous experience and with that of similar hospitals. Estimates of staff requirements are studied by the hospital consultants, who are trained hospital administrators familiar with every hospital in the province. Finally, in the light of policy laid down by the government, the estimates are reviewed by the Hospital Rate Board, which consists of the commissioner and the managers of the hospital finance, the consultation, and inspection divisions. Any changes considered necessary are made and per diem rates for the year are established.

Example:

Hospital estimate of occupancy	10,000 days
Approved gross operating cost	$160,000
Sundry revenue	$ 30,000
Net cost	$130,000
Per diem rate	$13.00

Obviously no hospital can render its exact estimate of days, and that is where the firm rather than a fixed budget principle applies.

There are many overhead or standby costs such as salaries, heat, light, and so forth, that go on regardless of the number of patients. If a hospital gives fewer days than estimated, the only saving would be for food, drugs, and a few other supplies. These are called variable supply costs, and in the hospital in question would amount to about $2.75 per day. Its $13.00 rate, therefore, represents $2.75 for variable supply costs and $10.25 for standby costs. Similarly, if the hospital had extra days, the only additional cost would be for the variable supplies.

Donald M. Cox.

Under the application of the firm budget policy, if the hospital gave 300 days less care than estimated, the Hospital Insurance Service would pay $10.25 per day for the unused days. If there were 300 days above estimates, the Hospital Insurance Service would pay $2.75 per day for them, which represents the additional expense to which the hospital was put.

There are, of course, a few instances where fluctuations in days are sufficiently great to require additions to or reductions in hospital staff and other overhead costs. In such cases the necessary adjustments are worked out with the hospital.

Payments to hospitals average close to $100,000 per day. In the period from January 1, 1949 to August 31, 1958, $225,000,000 were paid for over 2,675,000 claims*.

Every effort is made to preserve the autonomy of local hospital boards. The Hospital Insurance Service determines, in accordance with the policy established by the government, how much money it can allocate for hospital care; but once a budget is established, the expenditure of those funds is at the discretion of the hospital board. If a hospital decides it will spend more on one class of employee and less on another, or more on one service and less on another, that is entirely its own affair. Any hospital that is not satisfied with its established per diem rate can ask that its budget be reviewed with the Rate Board. If still not satisfied, any hospital has the right to appeal to the Minister of Health and Welfare.

Everything possible is done to assist hospitals to build up funds for building improvements, equipment needs, and so forth. If donations of foodstuffs, linens, and other supplies are received, the hospital is entitled to charge them to expense accounts at fair prices and transfer an equivalent sum to non-operating funds. Similar procedures are followed if services are donated, such as a women's auxiliary doing the sew-

**Includes 2,100,000 in-patients, and 575,000 short stay.*

ng. When hospitals are operated by religious orders, they are entitled to charge full salaries for their members, and it is entirely their own affair what they do with those funds. You will be interested to know that the activities and fund-raising campaigns of women's hospital auxiliaries in B.C. have a good deal more than doubled during the less than ten years that the Hospital Insurance Service has been in operation.

When I attended the American Hospital Association meeting recently a group of hospital and health people asked me to explain our hospital insurance service. After I had finished, one of them said, "Well, I guess everyone is pretty happy with your plan." I replied that I was satisfied that the people of British Columbia and the hospitals appreciate fully the protection from hospital bills available to every resident and the assured hospital income that their Hospital Insurance Service provides in a measure that no voluntary plan can equal. In all honesty I still had to tell them that it is not possible to provide everything that the public may desire and that when we meet with hospital board members and administrators at their annual convention, they usually advance criticisms and propose changes that they feel would benefit their hospitals. I added, however, that I am satisfied that, if there were ever a serious suggestion that the hospital insurance service be discontinued, all the hospitals and, with few exceptions, every citizen would be up in arms.

To my mind, the desire of the people for extension of benefits and the pressure from hospitals for policy changes or allocation of more funds for payments to hospitals are an indication of healthy interest in the program.

In the early days of our Hospital Insurance Service, people spoke rather casually of free hospitalization. We did our best to discourage that suggestion. If the people of a province are to enjoy the tremendous benefits of a province-wide hospital insurance service, one of the prices is facing up to the responsibilities that must be met.

As one reviews the operation of a province-wide hospital insurance plan, it becomes apparent that practically everyone in the province, either individually or collectively, has a certain responsibility to the Service.

Responsibilities

You might be interested in a brief outline of some of the individual and collective responsibilities that have become apparent to me through my association with the B.C. Hospital Insurance Service. I am quite sure that these responsibilities will apply similarly to the hospital insurance programs of other provinces.

The federal government, through the passing of the Hospital Insurance and Diagnostic Services Act, the approval of regulations, and the signing of agreements, has assumed a responsibility to underwrite what will, on the average, amount to approximately 50 per cent of the cost of payments to hospitals on account of hospital care. You are familiar with the basic details of the federal-provincial arrangement whereby the federal government contributes to the cost of hospitalization plans that meet basic federal requirements, but leaves the administration of the plans to the respective provinces.

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In Alberta — co-insurance

J. D. Campbell,
Edmonton, Alta.

THE introduction of the hospital insurance plan in Alberta represents an adjustment in sharing costs, thus making services more widely available. I mention this because I do not wish to have the slogan of "dollars versus level of service" badgering us, although I must admit that it is used extensively in arguing about the problems arising in the development of any hospital insurance plan. However, as long as high quality service remains scarce, it will have a dollar value.

During the development of the Alberta plan, it was soon evident that certain specific groups were involved in the financing. These groups would meet the costs of the services under the proposed plan—the individual patient or his agent, the municipality, the provincial government, and the federal government. One of the main problems facing us was deciding on the group which should bear the responsibility for residual costs. Under the voluntary plans already operating in Alberta before April 1, 1958, this responsibility rested with the municipality or, in the case of a privately operated institution, with the private organization.

A review of the costs indicated that a fairly significant portion was fixed costs, or, as we have termed them in Alberta, "standby costs". These represent the costs which are required for providing hospital care before the patient enters the picture. When the patient is admitted to hospital, variable additional costs are then incurred. It was decided that the patient should be responsible for these additional costs, and should pay an amount approximately that of these costs. Out of this came the co-insurance which is charged to each patient under the present Alberta plan. This ranges from $1.50 to $2.00 per patient day. It was felt that this payment should not be varied with the changes in costs except when the variable costs of hospitalization rose higher than the rates set for any given area.

This graduated co-insurance payment is based on the size of the hospital—a setup similar to former plans. No attempt was made to alter this, as it was felt that minimum adjustments should be made in implementing the revised plan.

Where the province had previously extended aid, no change was made. This is illustrated by the fact that the province accepted the responsibility under the new plan for the co-insurance for which the patient would usually be responsible—for social service recipients, maternity care, arthritis, cancer and polio patients. Because of co-insurance our plan does not involve as much socialization as appears to be an aim of the pre-

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Mr. Campbell is director of hospital services, Department of Public Health, Alberta. This article is from an address given at the Western Institute, September, 1958.

sent federal-provincial hospital plan. I regret that no credit for this can be extended to the federal authorities, since Alberta is being penalized because of it—as the co-insurance payment is deducted from the total costs in the determination of shareable costs by the federal government.

The second step to be considered was the inter-relationship of the provincial and municipal governments over the balance of the costs after the patient's payment. Because of rising costs, the municipal bodies agreed that their responsibility should be a basic amount. Because of the difficulty of determining the individual municipality's contribution, and because the municipality operates under a property tax structure, it was decided that the municipality's contribution should be set at a maximum of three mills based on an equalized assessment. Before April 1, 1958, persons eligible for hospital benefits under the provincial-municipal plan were limited to the hospitals in their own area (Municipal Hospital District) or to areas covered by an agreement made by the local municipalities, unless the individual *required* hospital care in another area as a result of an emergency or referred situation. This meant that municipal contributions varied from two mills to 16 mills or higher. Under the proposed plan, free choice of hospitals by the residents was adopted. These factors represent the fundamental reasons why the basic mill rate was determined as the municipalities' contribution. This statement refers to operating costs only.

On the basis of the above, the province accepted the responsibility for residual operating costs, although, with the increase in the equalized assessment or a change in the mill rate, varying contributions will be made by the municipalities. When the federal government signed the agreement with the province on July 1, 1958, the basic principle followed was that the federal government would assume approximately an equal share of the operating costs which were borne jointly by the province and the municipality under the Alberta plan which became effective April 1, 1958.

Doubt about the fairness of the pattern of contributions outlined might be expressed; particularly so because the responsibilities for meeting residual costs shared between the province and the municipalities are different from those shared between the federal government and the province. The federal government has taken a specific stand on the co-insurance payments, and therefore the sharing of the operating costs by the federal government is modified by the amount of the co-insurance payment. It is here that the province of Alberta feels that the formula for sharing costs used by the federal government is not equitable among the provinces.

Capital Costs

The responsibility for hospital capital costs used to be the responsibility of the municipalities or the private organization when the hospital was operated privately. Inasmuch as the municipally-owned hospitals relied upon the municipalities to cover capital cost, the private hospitals found that they were being asked to make a very substantial contribution towards hospitalization. In drafting the Alberta plan, this inequity was removed, and it was made mandatory for the municipalities to accept the responsibility for the capital costs of hospitalization of their residents no matter where they were hospitalized. Section 12, subsection (1) of the Hospitalization Benefits Act states, "each municipality shall make provision for the hospitalization facilities required for the hospitalization of its residents."

In order to apply this, it was necessary to set up individual capital cost rates for each of the approved hospitals in Alberta and to organize a billing procedure by the individual hospital to the municipality for its hospitalized residents. This procedure has caused considerable administrative difficulty; I am certain that everyone recognizes the difficulties which are encountered when an attempt is made to determine whether or not an individual is a resident of a particular area. To date we have had very good co-operation from the municipalities; and the hospitals are finding their collections quite satisfactory.

In determining the basic capital costs for each hospital, this formula was used—the annual repayment of debentures for the hospital, plus the annual interest payable, plus depreciation on equipment computed for the year, divided by the number of patient days on an assumed 80 per cent occupancy. This formula was applied instead of using depreciation of buildings, as the pattern of outstanding hospital debt varied throughout the province, and the actual cash requirement was more realistic for the municipalities. It would, therefore, be more acceptable as a reasonable basis of determining their responsibility than if depreciation of buildings were used.

It has been announced recently by the Alberta government that the provision inserted in the Hospitalization Benefits Act—"If the province of Alberta enters into a hospitalization agreement with the government of Canada whereby a federal-provincial hospital insurance scheme becomes effective in Alberta, the Minister may, upon the approval of the lieutenant-governor-in-council, make provision for the payment of sums for capital costs not exceeding in the aggregate the amounts contributed by all municipalities for approved operating costs," (Section 14) (4) —would be brought into effect January 1, 1959. This means that the responsibility of the municipalities for capital costs will be taken over by the provincial government. This is the first step in routing back to the municipalities part of the shareable costs received by the province from the federal government. It is estimated that the amount of relief will approximate the amount of contribution which the municipalities will be making towards the operating costs. However, since the federal government is sharing the operating costs borne by the municipalities in the form of a three mill assessment the extent of the relief, which otherwise would accrue to the province and which is passed on to the municipalities, would be approximately one and a half mills.

In Alberta, the hospital bed situation is perhaps the most favourable of any of the provinces. There are approximately seven active treatment beds available per thousand people. Therefore it is assumed that in Alberta the need for additional beds will be levelling off. Realizing this, we have approached the federal government about construction grants, requesting that the grant terms be altered, so that the provinces may use the grants to include payments on capital costs as well as actual construction costs, or a combination of the two, as an alternative. If this is done, Alberta will not be faced with pressures in hospital construction, merely to use the construction grants. Because of the development which has taken place in Alberta in meeting the prob-

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S.H.S.P. — a partnership

F. Burns Roth, M.D.
Regina, Sask.

HERE I propose to review very briefly some of the salient characteristics of the Saskatchewan program of hospital insurance, and then make some general comments on the question of the partnership of hospitals and government. I see no real purpose in making any detailed summary of the Saskatchewan Hospital Services Plan. Instead I will outline some of its important characteristics, referring to it from time to time as "the plan".

Saskatchewan's venture into comprehensive hospital insurance began on January 1, 1947. The major premises which were accepted then have been modified very little in the succeeding 11½ years, except for the extension of some benefits. These are the basic premises:

1. The plan should be compulsory for all persons residing in the province after a waiting period.

2. Aside from a general waiting period applicable to all new residents there are no exclusions for pre-existing conditions, or because of age or amount of service required.

3. Services should be at standard ward level and should be in the hospital of the patient's own choice. Benefits are extended as long as the patient's own physician certifies that care in hospital is required.

4. Local hospital authorities are responsible for the capital costs as well as for the operation of the hospital. In the case of construction, the size and type of hospital is subject to the approval of the Minister of Public Health. In the matter of operation, a set of minimum standards has been formulated which are subject to enforcement by the Minister.

5. The hospital is financed by a personal tax collected, in most instances, by local governments. In addition, more funds are provided out of sales tax and from the consolidated revenue fund.

6. Payments to hospitals are made upon submission of a budget and payments will meet the full cost of reasonably efficient operation.

Now—a word or two about some characteristics of the Saskatchewan plan which make it different from other plans and some reasons why these differences have been accepted.

Method of Fund Raising

Funds to operate the plan come from three sources—a personal tax, a sales tax on a limited variety of commodities, and a subsidy from general revenues.

It is quite clearly recognized that the payment of the personal tax is a matter of individual responsibility. However, when the individual's financial circumstances are such that he cannot pay the tax, the responsibility for its payment rests on the municipality, the province, or, in special cases such as Indians, the federal government. There is a belief in my province that the virtues in a personal tax payment outweigh any problems in collection. We feel that a personal tax gives a sense of participation — almost everyone knows that this is *his* insurance program.

The sales tax applies to all commodities except food and a few items closely related to agriculture. Although one could argue that a sales tax is really not a progressive tax, it at least has the virtue of securing greater contributions from those who spend more.

Co-Insurance or Deterrent Charges

We have not applied any type of co-insurance or deterrent fee. Our reasons for this are somewhat complex, but basically we believe that co-insurance can be viewed three ways.

(a) We can look at it as a means of pointing out that hospital services cost money—that, in other words, nothing is free. In our case, we believe the personal tax payment does this just as well, or even better.

F. Burns Roth, M.D.

(b) We can regard it simply as co-insurance. This assumption, if followed logically, would lead us to see it as some sort of penalty in the form of a partial payment demanded because an individual fell sick. Although a small number of people become ill or injured through faults of their own, I think we must agree that most cases of illness or injury must be considered as unwanted and unavoidable.

(c) We can also view co-insurance as having a deterrent effect against unnecessary use of hospital care. There is no question but that a co-insurance charge, if high enough, will be effective in discouraging people from seeking admission to hospital. Unfortunately, the greatest effect of any deterrent falls on those least able to meet it. It should also be remembered that those least favoured economically have the greatest illness rates in our society.

Therefore, we have not accepted the idea of a co-insurance or deterrent charge.

Depreciation and Interest Charges

We allow hospitals to include as an expense item in their operating costs an amount for depreciation on plant and equipment, the annual charges being spread over the useful lifetime of the asset. Originally the concept of depreciation in hospitals was similar to that in business, namely, that depreciation on the plant was a proper charge against operations and that it might be used to replace the plant at some future date. Our own thoughts have changed subtly through the past ten years.

Dr. Roth is deputy minister, Department of Public Health, Regina, Sask. From a paper presented at the Western Canada Institute for Hospital Administrators and Trustees, Winnipeg, Man., September, 1958.

Some persons have raised a question as to whether one should really plan on replacing any hospital by this method. They argue that it may not be desirable to replace the hospital since the need for it may have disappeared in 40 or 50 years. They also suggest that it is really not the responsibility of this generation to try to provide a hospital for future generations. Admittedly, these arguments have some weight.

But there is another argument to be advanced, which, in my opinion, justifies the payment of depreciation. That argument goes something like this. We all know that there is an increasing centralization of hospitals, with institutions at the larger centres rendering services to residents of distant areas. Clearly those distant areas should contribute in some way to the cost of erecting and operating the complex and expensive larger institutions. This can be done in several ways:

(a) As in British Columbia, where a large portion of the total capital cost of hospitals is met by the central government.

(b) As in Alberta, where each municipality is required to pay a capital charge on behalf of each of its residents who are hospitalized.

(c) By considering depreciation as a means of spreading capital costs over the whole province.

We have stuck with the last arrangement.

Now—a word about interest charges as an expense of hospital operation. Our attitude is that interest payments should not be recognized as an expense of operation which will be met by the plan. Our reasons for this are again a bit complex, but basically we regard interest payments as a local responsibility. Part of this stems from the premise that the kind of hospital a local community provides for itself must be determined by that community, subject, of course, to general over-all provincial planning. We, at the provincial level, feel that if no financial responsibility rests with the local community, local autonomy may be weakened and we may see increased centralization of hospital affairs.

Our thesis can be summed up this way: We believe that some measure of financial responsibility must remain with the local community as far as capital costs are concerned. Interest charges are one of these elements which we feel are best met locally, capital principal is another. We do suggest, however, that allowed depreciation expense does have some effect on spreading the burden over the whole province.

I will be the first to admit that we must continue examining the whole area, and I would suggest that in looking at these problems we must consider not only the immediate needs but the long-term trends which might develop from meeting these needs.

These, then, are the general premises—and a final word of comment should be made about them. I want to emphasize that the premises which we believe are reasonably effective in Saskatchewan may only be totally applicable to Saskatchewan. It has always seemed most important to me to point out that the factors in my province which make these premises workable may not be present in other provinces. For example, we can make a personal tax system work in our province because we have a large number of organized local government areas. They have accepted the idea of collecting the tax, and it has worked. In a different setting with a different kind of local government, this might not work nearly so well. It might even be impossible.

So I would stress that we must watch what others are doing—with the object of seeing how they are meeting their problems rather than with the idea of slavishly copying them.

Inter-relationship

I should like to deal now with the whole question of the partnership of government and hospitals in a much more general way. In approaching this subject, we might look first at the rôle of the hospital in our society, and then at the rôle of the government. After this, we can see where they inter-relate.

Our society has reached its present state of development by a process in which many of our social institutions developed along parallel, and then gradually merging, paths. Sometimes these paths diverged for a while. Hospitals, for example, developed pretty much by themselves for a long time. The medical profession also developed alone, and for many centuries had not too much to do with hospitals. Nursing, on the other hand, developed more in conjunction with hospitals.

Gradually co-ordination among these entities grew up — physicians began to attend patients in hospital, a liaison between medicine and nursing was set up, various other disciplines such as biochemistry came in. We now see the hospital as an organism within which several skills and disciplines flourish and develop. We have come also to accept the hospital as an element in our society with goals of its own. We have come to accept the fact that, as in any functioning organism, there must be order and organization and a unity of purpose. So we see the modern hospital—it has an avowed set of objectives; it has an organization structure which has evolved in a commonly accepted pattern; and it makes certain demands and in turn provides certain privileges. We have come to accept the idea of a nursing hierarchy with supervision from the top down, and we accept the idea of a medical staff organization with staff controls, supervision of technical and professional procedures.

In the long history of man's search for health, this modern concept of the hospital is really a relatively new phenomenon. One might even question whether all members of the hospital organization fully accept the idea of the hospital itself having a goal which must be sought by all concerned. Certainly all do not accept the idea that inherent in seeking a common goal is the need for organization and supervision.

I would suggest that society is now saying — with varying amounts of emphasis—that we must look at the hospital in its total setting, *i.e.*, the community, to see what the hospital's responsibility to the community really is. This idea is now only dimly understood, and I propose to examine it briefly by asking a few questions.

Is the idea sound? Should the hospital be concerned about its rôle in the community, and should it be concerned about whether the services it performs are viewed in terms of total community need?

I presume that we must accept *a priori* that the rôle of the hospital is to serve the public. Sometimes I wonder whether this goal is always kept in mind—do not some hospitals believe, or act, as if they had a commodity to sell, a commodity which must be merchandized, advertised and promoted without much regard to

its cost or quality? Fortunately these institutions are few and far between. But we must admit that society must be concerned if a public service institution like a hospital is selling a shoddy product for a high price.

I can see no way in which we can reach any other conclusion than that hospitals must have as their main goal service to the public. What we must do is examine our daily conduct, our attitudes and every decision we make in the light of this thesis. Sometimes I wonder whether we always do this. Do not our own interests, our ingrained habits, our resistance to change and our unwillingness to be unpopular sometimes come into play when we are forced to make an evaluation as to whether the course of action we take is in the public good?

If hospitals have this service to the public as their main goal, they must then look at how they fulfill their rôle.

Let me make a categorical statement here—one which I would suggest, should be the banner leading all health personnel into the battle against disease. "The fundamental goal of all health services should be to make their services unnecessary."

I said this to a group of medical students who were just completing their course and I'm afraid the immediate impact was rather drastic. Some of them looked at me as if I were a bit addled; some of them seemed to wonder whether they had just wasted four years of study. Still, I would submit to you that we are deluding ourselves if we fail to see that our long-range goal is to make (as far as possible) hospital, medical care, and health services eventually unnecessary.

I do not want to be misunderstood here. I am not saying that we should close the doors of any hospital, that we should render any less medical care, that we should fold up any of our other health services. What I do want to say, however, is that we must view everything we do in our activities as health workers in the light of whether what we do today is leading to a disease-free tomorrow.

In so doing, we must be realistic enough to recognize that we may never reach our goal; this is no reason for not trying to come as close as possible.

What implications has this on how our hospitals develop and what we do in them? Some may say it has nothing to do with our job as hospital people. Our job is to render treatment, to cure if possible, to provide palliation if cure is impossible, and not to be concerned with the highly theoretical concept of putting ourselves out of business.

On the other hand, others of you may have looked at your rôle in this way already. You may have

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M.H.S.P. — understanding

G. L. Pickering,
Winnipeg, Man.

MANITOBA's hospital insurance program went into operation on July 1, 1958, and so has been operating for only a few months. There are a good many administrative problems still facing us, but when these are considered in the light of the problems which have been overcome during the past months, we are now confident that the plan is on a pretty sound basis — and is functioning quite satisfactorily. The hospitals of Manitoba must be thanked for the wonderful co-operation they gave the plan from its very inception. This whole venture has been indicative of the co-operative spirit existing between the plan and all the various groups with which we on the commission have worked. Had this not been so, the plan could never have started when it did, and provided that the same spirit of understanding and harmony continues, there is little doubt that the whole program will be successful in doing what it is intended to do.

Since the Manitoba Hospital Services Plan is a new program, many from outside Manitoba, naturally, know less about it than about the plans in Saskatchewan and British Columbia which have been in operation for some years. I will, therefore review the highlights of the M.H.S.P. following a few general remarks on government hospital relations.

First of all, I would think that the relationship between a government-sponsored hospital plan and hospitals should be based on the same general principles which apply to the relationship between any groups of people working towards a common goal. If, for instance, this relationship is really one of a partnership, which we think it should be, then one of the fundamental principles must be co-operation and understanding of each other's responsibilities and problems.

The government, and I use the term here in its proper sense, representing the will of the people, has the responsibility of enacting legislation under which people as individuals and groups can carry out the legitimate activities which they choose to pursue and which have been entrusted to them by society. Within the scope of this legislation, those employed by government as public administrators and those employed by other organizations must, of necessity, work in harmony to achieve the goal which the government had in mind when enacting the legislation. There are few places in our society where this harmony is more essential than in the hospital field since both governments and hospitals have a vital interest in the health and well-being of the people.

Although this co-operation can be achieved more easily by sound legislation, a great deal depends on the willingness of those employed by governments and hospitals to work together in a congenial manner. Government, of course, besides considering the individual hospital must also take into account the total hospital picture. Each hospital on the other hand is naturally, as it should be, more concerned with its own organization. The coming together of these broad and local interests should result in the development of highly efficient organizations in the total hospital program.

During the years I spent in the hospital field, I was always impressed by the spirit of dedication and initiative which hospital administrators displayed. I would hope that the same spirit of initiative will be continued under a gov-

Mr. Pickering is commissioner of hospitalization with the Manitoba Hospital Services Plan, Winnipeg, Man. He gave this address at the Western Canada Institute in September 1958.

ernment-sponsored hospital insurance program — in offering the constructive criticism and ideas which have been so characteristic of the past. This is not only your right—it is your duty. The hospital administrator has a duty to bring to the attention of government any problems or difficulties resulting from, or likely to result from, government policies or administrative procedures. On the other hand, hospitals should remember that since governments are concerned with the entire hospital field, they must adopt policies and procedures which occasionally do not completely satisfy each individual institution. The common good must be considered in each government decision. This, of course, is a fundamental principle with which you are all familiar.

The relationship between a government-sponsored plan and hospitals must also be based on mutual respect and confidence. To achieve this, each must be honest with the other. Should this relationship degenerate to a battle of wits, it is quite apparent that the result will be far from desirable.

Hospital people, of course, should be allowed as much freedom as possible to operate their institutions within the framework of the general, over-all legislation. As you know, the great development in medical science and hospital standards has taken place largely under conditions where those making the contributions have worked with the most freedom. As well as ensuring that basic standards are maintained under a government plan, it would seem best that a great deal of latitude be left to local institutions — so they can operate as autonomous organizations developing their own personalities.

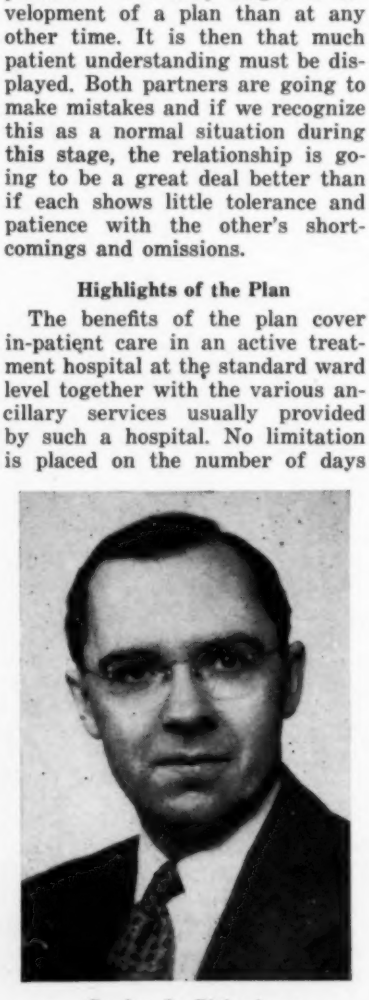
Governments and hospitals must co-operate in every way possible to encourage the continuation of voluntary assistance to hospitals. This is vital since the plans which are being introduced provide only for basic care and treatment. Therefore, assistance from voluntary groups is necessary to provide certain amenities which governments cannot provide. In addition, voluntary effort is necessary to provide certain capital funds in order to ensure that the physical facilities of the hospital are maintained at a desired standard.

Under government hospital insurance, the duty of hospital trustees and administrators to exercise the same meticulous control over hospital finances is not eased in the slightest. It is essential that hospital administrators adhere to the basic principle that they are spending public funds, and as trustees of such funds, should do everything within their power to ensure that these funds are spent to produce the most effective results. On the other hand, governments have a duty to be fair with hospitals in providing sufficient funds to enable the institutions to provide a desirable standard of care.

Under a program of this type, both the plan and hospitals have a public relations job to do. Since we have assumed a partnership, then each partner has a duty to explain the intent and spirit of the legislation to the public. Each should attempt to understand the other's problems and interpret these to the public so that the good will of the public can be maintained. This is possibly more important in the early stages of development of a plan than at any other time. It is then that much patient understanding must be displayed. Both partners are going to make mistakes and if we recognize this as a normal situation during this stage, the relationship is going to be a great deal better than if each shows little tolerance and patience with the other's shortcomings and omissions.

Highlights of the Plan

The benefits of the plan cover in-patient care in an active treatment hospital at the standard ward level together with the various ancillary services usually provided by such a hospital. No limitation is placed on the number of days of care as long as such care is medically necessary. The plan does not include domiciliary care, nor does it include the type of care which can be provided in a nursing home.



Gordon L. Pickering

Out-patient services are covered when emergency diagnosis and treatment is provided within 24 hours of an accident.

In hospitals where there is semi-private and private accommodation this type of accommodation will be provided, if available, to the patient on payment of the additional daily charge. Semi-private rooms in a hospital are restricted to those containing no more than two beds and the maximum additional charge for a semi-private room is set at $2.50 per day. There is no co-insurance under the plan.

All hospitals, except certain contract hospitals and those owned and operated by the federal government, are required to submit budgets to the plan each year for review by a Hospital Budget Committee. Final approval of the rates of payment rests with the lieutenant-governor-in-council.

Hospitals are paid by the method known as the "variable and fixed formula" which is similar to that used in Saskatchewan and British Columbia. Each hospital receives: (1) semi-monthly fixed payments; (2) monthly variable payments of $2.00 per day; and (3) monthly payments covering capital costs.

Provision is made for a retroactive adjustment in the rates paid to hospitals at the end of the year based on the actual financial experience during the year.

In addition to shareable costs, payments are made by the plan to cover depreciation on buildings and interest on approved capital debts. Fifty per cent of the net differential room charges are credited to capital costs and the balance is paid to the hospital by monthly payments.

Hospitals are required to deposit all capital cost payments in a capital fund bank account and these funds can only be used for certain specific purposes such as: (1) payment of interest on approved capital loans; (2) payment of approved equipment purchases; (3) repayment of approved capital loans; and (4) payment of the cost of approved construction.

Payments are made to contract hospitals and those owned and operated by the federal government on the basis of a daily rate based on comparable costs in other

Manitoba hospitals of similar size with similar facilities.

In general, out-of-province hospital care and treatment is covered by the plan up to a dollar value based on the cost of providing the care and treatment in a comparable Manitoba hospital. The rates run from $11.00 per day in hospitals up to 100 beds; $15.00 per day in hospitals up to 500 beds; and $18.00 per day thereafter.

Provision is made to enter into a reciprocal agreement with another participating province to pay the hospitals in the other participating province on the same basis as they are paid by the provincial authority in that province.

To qualify for payment an insured person must be admitted to a hospital on the authority of a duly qualified medical practitioner or a person registered under The Dental Association Act. There are certain restrictions on dental admissions.

The plan does not cover:

1. Out-patient care other than that provided within 24 hours of an accident.

2. Care and treatment provided in tuberculosis and mental hospitals, nursing homes, homes for the aged and institutions, the purpose of which is the provision of custodial care.

3. Such things as television and radio sets, telephones, et cetera.

4. Care and treatment which is the responsibility of the Workmen's Compensation Board or the federal government.

5. Professional services of an attending physician.

As you know, the Manitoba Hospital Services Plan is compulsory for all residents of the province.

The Hospital Services Insurance Act precludes any other insurance agency from offering the coverage provided by the plan to Manitoba residents. There is, however, no restriction against the issuance of policies covering hospital charges not covered by the plan.

Each year is divided into two six-month periods and payment of the requisite premium must be made one month before the subsequent benefit period begins, to avoid losing benefits. Otherwise benefits become available one month following the payment of the requisite premium.

The yearly premium rates for a family are exactly double that of a single person—the single exception being in the case of rates applicable to members of the regular Canadian Forces and the R.C.M.P.

Premiums are payable by two methods:

1. Employers with five or more persons on their payroll are required to remit premiums on the employees' behalf during the six month period ending one month before the subsequent benefit period begins — there are approximately 4,500 of these groups.

2. All other residents are required to remit premiums through the municipality, local government district, or directly to the plan if they reside in an unorganized area. The pay periods in these cases cover the two month period ending one month before the beginning of the next subsequent benefit period — there are approximately 205 municipal and local government districts.

Persons leaving the services of an employer are provided with a form indicating the last month for which a premium instalment was remitted. This form is either presented to the next employer or to the municipality if the person is not re-employed before the November 30 and May 31 next following.

New residents of the province are required to register and pay premiums within one month of taking up residence. They are then eligible for benefits one month following such registration and payment of premiums.

General premium rates: single, $2.05 monthly, and $24.60 yearly; family, $4.10 monthly, and $49.20 yearly. Special premium rates for regular members of the Canadian Forces and the R.C.M.P.: with one dependent, $2.05 monthly; with two or more dependents, $3.10 monthly.

Initial registration for the plan took place during the period April 10 to May 31. On July 1, 1958—98 per cent of the population or about 850,000 persons had registered.

Insured persons who leave the province to take up residence elsewhere are entitled to three months coverage from the date of their departure.

Certain residents of the province are eligible for benefits under the plan upon registration without payment of premiums. These include all recipients of public assistance such as persons in receipt of Mother's Allowance, Blind Person's Allowance, Disabled Person's Allowance, Old Age Assistance (65 to 69 years of age) and wards of the government. Residents who are 70 years of age and over and in receipt of the Old Age Security Pension are also exempt from the payment of premiums if they apply for exemption and it is determined that they would qualify for Old Age Assistance if they were under 70 years of age.

Other Features

Pension groups — Former employees of a firm may pay their premiums on a monthly instalment basis by means of deductions from their pension cheques upon the conclusion of an agreement in this respect between the firm and the plan.

If a husband and wife are both employed, only one of them (it does not matter which one) is required to register and pay premiums as a family head. The spouse who is a dependent must complete an "Exemption Certificate of Employed Spouses" through his or her employer.

No additional premium is required for the benefit period in which a person becomes a *new* resident and a dependent. The person is covered for the remainder of the benefit period upon registration by the family head through his appropriate agent.

The plan does not change, in any way, the usual arrangements between insured persons and their physicians.

Where an insured person is a patient in a hospital and has not been discharged before another benefit period begins, in respect of which he has not paid the requisite premium, he will continue to be an insured person until he is discharged from the hospital. However, the person continues to be liable for the requisite premiums and is required to pay the premium to the appropriate agent *within one month of discharge* from hospital.

The estimated cost of the plan for 1959 is $27,000,000. Premiums are expected to yield $11,500,000 and the balance will be financed by contributions from the provincial and federal governments. The large contributions from the federal and provincial governments have kept premiums at the lowest possible level considering the broad and comprehensive benefits provided by the plan.

Now that the initial stages of developing the M.H.S.P. are almost completed, we expect to undertake a continuing educational program to familiarize the public with all phases of the plan. As you well know, this plan will be much more effective if it has the active support and understanding of all the people of the province. ■

The Princess Margaret Hospital

A MODEL WITH A MISSION

Architects
Allward & Gouinlock
Toronto

operated by the Ontario Cancer Institute

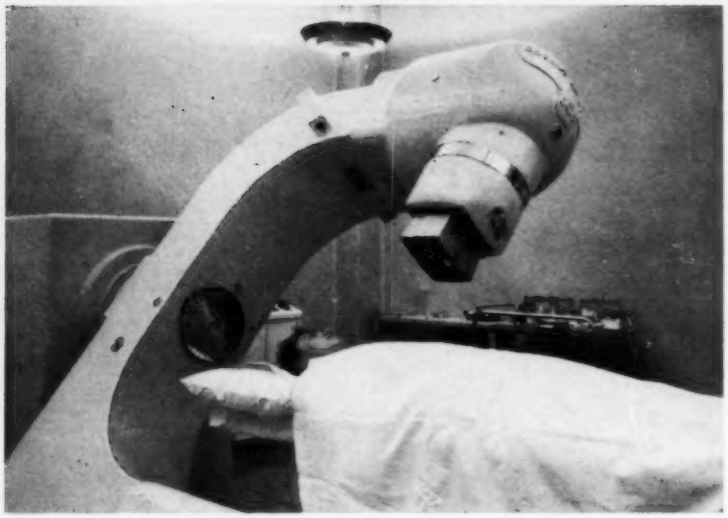
AT 500 Sherbourne Street, Toronto, stands the new Princess Margaret Hospital — this is no ordinary hospital. It is part of the Ontario Cancer Institute, and is, perhaps, unique in this part of the world.

The Institute, incorporated by provincial Act in 1952, functions under a board of trustees representing the Ontario Cancer Treatment and Research Foundation, the University of Toronto, and three major teaching hospitals. It was the duty of this board to plan, construct and establish buildings not only for cancer research, but the diagnosis and treatment of cancer, and the observation of, and consultation with, persons suffering from this disease. It would be a model of its kind, since throughout the world there are relatively few centres designed for these particular purposes.

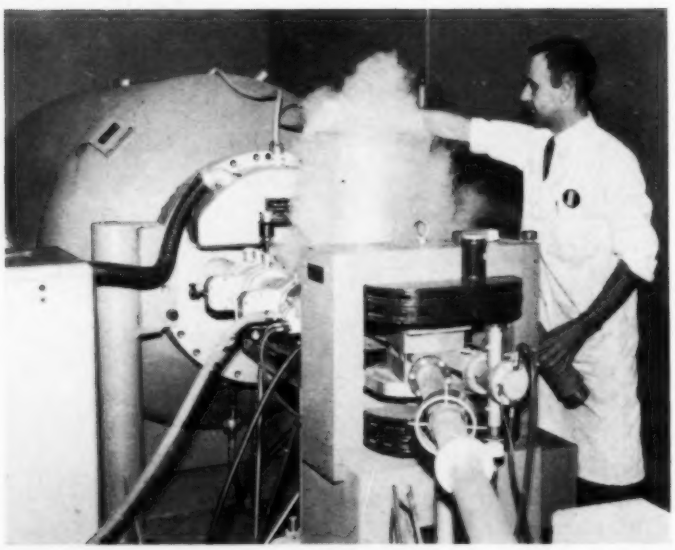
From the fall of 1954 construction and administrative organization proceeded apace to culminate in the finished, seven-storey, ultra-modern structure that was officially opened on September 25, 1958. Now Canada has one of the world's finest centres for cancer research which operates and manages a provincial hospital for cancer diagnosis and treatment. The Institute's board of trustees now is composed (as under Ontario's Cancer Act of 1957) of twelve members who represent five teaching hospitals — the Toronto General, the Toronto Western, St. Michael's, Hospital for Sick Children and Women's College Hospital—the Ontario Cancer Treatment and Research Foundation, and the University of Toronto.

Costing about $7,000,000, the building has 75 per cent of its space reserved for patient care; the remaining 25 per cent is devoted entirely to research. Patients who come to this hospital for radiation therapy are all referred by other hospitals or practising physicians throughout Ontario as far north as the head of the Great Lakes.

Exemplifying a new trend is the Institute's 53-bed hostel, constructed with funds from the Canadian Cancer Society. This

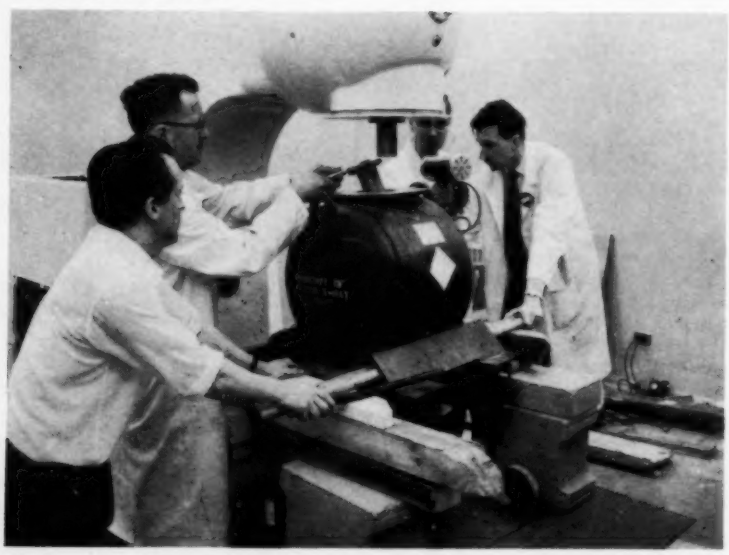


The hospital's own rotating x-otron. In its head is an x-ray tube.



Liquid air is poured into the Van der Graaf.

Loading the source from its lead case into the x-otron's head.



hostel, only a few steps away from the main building, is for those out-of-town patients who do not need to be admitted for in-patient care, but must present themselves for daily treatment and supervision. Equipped with comfortable furnishings — even television — the hostel makes it possible for these patients to live a "normal active life in a home-like environment."

But what of the main building itself? The most modern facilities and conditions conducive to progress in medical science are housed beneath its roof. The top three floors concentrate on research. On the seventh are located compact, tidy laboratories which can care for 10,000 to 15,000 small animals — mostly mice at the present time — in which cancer cell growth is being studied. From Chalk River, Harwell and Oak Ridge come the radio-active gold, phosphorus, cromium, iron and iodine which are used both in research and in clinical work with the patients. These minerals are stored on the top floor to be as far away as possible from radiotherapy machines housed on the bottom floors of the Institute. On this floor too, in well equipped laboratories, the department of physics probes into problems in nuclear research related to radiation therapy in human beings.

The biological research laboratories take up the sixth floor, where fundamental research on cancer's nature is undertaken. It has subdivisions of histology and experimental pathology, immunogenetics and cytology, electron microscopy, microbiology, haematology, tumor-host physiology and biochemistry, and immuno-chemistry.

The floor below houses facilities for clinical investigation of patients suffering from cancer. A small 8-bed ward here is for studying problems such as why cancer patients lose weight and energy, and why radiation therapy causes nausea in some patients. As new treatments are developed they will be carefully given to selected patients in this ward. Meals for these patients are precisely made up by exact weight of each food type, and frozen before the study begins. In this way it is possible to calculate, through various analyses and daily weighing, what is going on in the body under a certain set of circumstances. There is a patients' sitting room and library on this floor, as well as on the two floors below.

These next two floors, the fourth and third, are those that serve as the 87-bed hospital for in-patients. Here is the 10-bed children's ward, which includes a bright and airy playroom, furnished with tot-sized facilities.

All adult accommodation is in one- or two-bed rooms, each with an adjoining bathroom and a locker for each patient. And, of course, the rooms are fitted out with the latest furnishings and the most sunny, home-like decor possible.

The second floor provides space for the pathology department, the records room, central sterile supply, and the Institute's library. Also on this floor are the operating and recovery rooms for surgery connected with the giving of radium therapy. No general cancer surgery is done here. The Institute also has a dental department—concerning itself with patients who have cancer of the mouth. Adjoining this, is the area where all the radium in the building is kept in heavy leaded safes.

Shielded and protected by thick concrete walls is the radiotherapy

The Betatron is used for deep x-ray treatments

department on the first floor. It contains all types of x-ray equipment, including ten cobalt units, one of which (the x-otron) was specially constructed in and for the Princess Margaret. The two caesium units, the Institute can boast, are the first installed in Canada.

Yellow-smocked auxiliary members serve tea in the sitting room.

A lecture room, built to hold 175 people, a linen room, cafeteria, and ambulance admitting area are found in the basement. The Institute's huge Betatron, which can produce x-rays with an energy equivalent to 22,000,000 volts, is installed in the basement too—although the machine's topmost parts extend upward a floor. Next to the Betatron's room is housed a 3,000,000 volt Van der Graaf generator, a source of atomic particles used for research, and for producing isotopes for treatments. Both these areas are protected by concrete walls, floors, and ceilings three feet thick.

Down here, also, a whole corridor is given over to the outpatient department — since most of the 2,500 patients the Princess Margaret Hospital expects to treat within its first year will be out-patient cases. The hospital also expects to examine as many as 15,000 follow-up patients in its clinics. In all, as well as clinical photography rooms, a biopsy room and a waiting room, there are 12 to 14 dressing cubicles and five examining rooms. Part of the outpatient department is concerned with the examination and follow-up of patients who have cancer of the skin on exposed parts of the body or cancer involving head structures.

In clinical work the hospital relies on advice and assistance from other Toronto teaching hospitals. Dr. C. L. Ash, director of the Institute, also heads the Clinical Services Division. The work includes three other main divisions — the Division of Physics, headed by Dr. H. E. Johns; the Division of Biological Research, where Dr. Arthur Ham is head; and the Division of Hospital Services of which John F. Law is administrator. Dr. O. H. Warwick is chief physician.

Because the Institute was intended to be a teaching hospital, affiliated with the University of Toronto, some undergraduate and much post-graduate work is carried on in the divisions. A department of medical biophysics has been established too, where, when it has been accepted by the University of Toronto's School of Graduate Studies, graduate students can do research leading to a Ph.D. Research is done independently by the scientists in each of the special fields, and also in co-operation with each other to provide a co-ordinated attack on problems considered most likely to lead to medical advances. This work, in part, is supported by the National Cancer Institute, which grants to fundamental research funds raised by the Canadian Cancer Society, the Banting Research Foundation, the National Research Council, and other public and private organizations.

The broad scope covered by the hospital's program, and its up-to-date facilities and equipment have, of course, attracted many internationally known professional personnel. These are people with a mission — a mission carrying with it a challenge to discover what this mysterious organism called cancer is, and how it can be controlled and mastered. Here at the Princess Margaret — in "model" surroundings—their theories and experiments can be fostered and developed to lead, we hope, to the answer to today's most enigmatic disease. The Princess Margaret is a hospital of which all Canada should be proud. ■

A challenge !

Development of a Dietary Manual

Sister Mary Loyola,
Halifax, N.S.

DIETITIANS, how would you answer the following questionnaire:

1. What creates the need of a diet manual?
2. Is a diet manual a necessity?
3. Is it sufficient to use a manual from a well-known hospital?
4. If your hospital realizes the importance of a manual, specific to its needs and policies, how would you go about formulating one?
5. How will it be used — as a teaching guide or procedure manual?

In the following article may be found some answers to the above questionnaire, gleaned from a personal experience. The Tower of Babel could not have presented more confusion than the multiplicity of diets used at one time in our hospital. Take ulcers, for example. The diet choice was enough to cause ulcers in any young doctor—Sippy, Lenharts, Herst, Meulengracht, Gastric 1, 2, 3, 4, and 5, Modified Sippy, Bland—eleven diets for one condition! This confusion forced .us to realize (a) that uniformity and simplicity must be reached; (b) that a clarification in the nomenclature of diets must be attained; (c) that a standard guide in diet needed to be made available to the hospital personnel; and (d) that our therapeutic diets should be nutritionally adequate, and based on the normal diet.

Our spade work lay along two avenues. The first was a diet survey based on the general patient diets, undertaken by our dietetic interns to ascertain the adequacy of the general diet *as consumed*. Once this proved sufficient, we were able to deviate for the therapeutic diets.

The second avenue was the opportunity to visit hospitals in Canada and the United States where diet manuals had been completed, and to confer with the authors. These avenues are not a must to reach the formulation of a diet manual, but they are enlightening and useful.

At the time we were struggling to get a foothold, the diet therapy section of the American Dietetic Association was working on the same project, their *Guide for Preparation of Diet Manuals*. Although we did not experience the benefit of the guide in our preparation, we were gratified that our work paralleled with their directives. The guide is a must to any one considering the development of a manual.

Our first step was to address the doctors at a staff meeting in order to explain the necessity of a diet manual. Our more modern doctors, as well as the highly experienced and more senior men, recognized the importance of diet as a prophylaxis and a curative in many conditions. Since they were eager to have the most up-to-date diets at their disposal, they gave a unanimous vote. A committee to represent the doctors was nominated. Such a committee should assume the following responsibilities: (1) make suggestions, (2) influence the entire medical and surgical staff to adopt the manual, (3) sponsor the manual, and (4) meet frequently with the dietary committee to discuss the diets. It is to be understood that those who serve on the committee are doctors representing all fields of specialization, and particularly those who possess a keen interest in and knowledge of nutrition and diet therapy.

Likewise, a committee of dietitians was set up to do the research work and to construct the manual — and to meet periodically with the dietary committee of the medical staff. Scarcely before the dietary committees had a chance to cut their teeth, a doctor suggested that the three major hospitals in the city combine and formulate standard diets to simplify the work for doctors who attended these hospitals. As a result, the three therapeutic dietitians worked together one day a week over a period of nine months. These meetings were the means of bringing about standardized diets, correct dietetic terminology, and a better interpretation of definite diets. They promised dietary unity, a better understanding between medical and dietary staffs of all hospitals, and a diminution of unnecessary overlapping of current diets.

To these meetings, the dietitians brought in assigned diets approved by their own committees. These were merged into one, and the result was criticized constructively and destructively. Finally the diet was actually tested by the three dietitians themselves to gauge patient reactions. The dietitians attempted to supply one diet for several conditions where formerly there were several diets for one condition.

Proper nomenclature was next considered. The name of the diet should be: (a) specific, designating, where possible, the amount of the essential nutrient under consideration, and (b) named according to the modification from the normal—*not* after the doctor who promulgated its use, *e.g.*, Kempner, Meulengracht. Nor should it be named after the disease for which it is used (poor psychology).

The various points to be checked in each diet before it was considered complete were: to give, after the correct name, the approximate composition of the diet; in concise terms, the principle involved; a complete list of foods allowed and foods excluded (the form should be the same throughout the manual and food groups listed alphabetically). If necessary, additional information would be listed in outline form at the end

(concluded on page 66)

The author is director of dietetics at the Halifax Infirmary, Halifax, N.S.

Food Service

sponsored by the

Canadian Dietetic Association

from doctor to disc via telephone

G. A. W. Currie, M.D.,
J. Arthur Keddy, D. Paed.
Toronto, Ont.

MOST of the medical dictation in Toronto's Hospital for Sick Children is transcribed by typists in the medical records department. Clinic notes and letters come from five individual dictating machines in our out-patient clinics. Four other machines in the operating rooms record operation notes. These nine dictating machines have all been retained, and the changes which are described here involve only the machines used for in-patient discharge summaries, discharge letters or progress letters—all of which are also transcribed in medical records.

When our present building was opened in 1951, nine other dictating units were placed at nursing stations, but difficulties were encountered — discs were lost and in-patient histories were held up. Five of these dictating machines were then moved to medical records, where for several years in-patient summaries and letters were dictated. This gave more effective control but meant that there was a delay before dictation could take place. When the patient was discharged the delay began with his medical record being sent to the medical records department. The delay continued, of course, until the doctor could come to the medical records department to dictate the summary.

In the fall of 1957, on the suggestion of a staff member who had been associate resident in medicine, thought was given to the installation of a telephone dictating system. Because of the cost and difficulty of separate wiring, an installation through our automatic switchboard seemed to be the answer. An already considerable investment in equipment was a factor in the final choice of three televoicewriters with voice operated relays. This voice control holds the machine in readiness until the first word is spoken. Thus gaps in the recording are eliminated. The equipment was installed on a lease purchase agreement in September 1957 and has since been purchased. Additional line charges per machine are a continuous expense paid to the telephone company.

The equipment, which can be dialed from any telephone in the building, gives a busy signal only on the rare occasion when all three machines are being used. It is possible for all discharge summaries to be dictated immediately on discharge of the patient. Although this goal has not yet been achieved, there are no technical difficulties in the way. The system is easier to operate than an individual dictating machine and is being used increasingly by our doctors.

The promptness with which it is possible to dictate summaries or letters gives a sense of urgency to the work, and we now have a more even flow of work into our transcription pool and hence out of it. Except for week-end dictation, transcription is completed daily.

We have not extended the use of the equipment and the transcription service to physical examinations, functional inquiries, complaint histories, progress notes, or consultation reports, since we believe it impractical to put the entire medical record in typewritten form. The filing of typewritten material is, of course, an important consideration and we have each typist place her own original copy on the medical record. Then the signature of the doctor is obtained.

We have found the telephone dictating system an aid in giving prompt information to our referring doctors, and a more rapid

Medical records supervisor can listen to playback on monitors and receive instructions by telephones at the side to help clarify dictation without removing disc from machine. —*Photos Courtesy Edison*

The authors, both of the Hospital for Sick Children, Toronto, are respectively, superintendent and director of medical records.

means of completing the medical record. Details of operation of the equipment can best be gained from a copy of the small sticker placed on each nursing station telephone and from the printed directions supplied to each doctor.

Sticker

Dial 8 to connect recorder
Dial 1 to start recorder
Dial 2 to indicate correction
*Dial 3 to listen to playback
*Dial 4 to indicate end of letter
*Dial 0 to contact secretary
*After 3, 4 or 0 dial 1 to resume dictation ■

Archivistes à Québec

Bertrane Royer,
Sherbrooke, Que.

L'ASSOCIATION Canadienne des Archivistes Médicales tenait cette année à Québec sa 24ème convention annuelle du 15 au 17 septembre. Une centaine de membres représentant toutes les provinces du Canada, de la Colombie Britanique à Terre-Neuve participèrent aux réunions qui se déroulèrent aux hôpitaux Saint-Michel-Archange, Jeffery Hale et Laval.

Le 15 septembre avait lieu à Saint-Michel-Archange une réunion du comité exécutif ainsi que l'enregistrement des membres. Une visite fut organisée à travers une partie de cette immense institution de 5,000 lits.

Le Révérend Père M. Meehan, recteur de collège Ste-Marie à Brockville, Ont., inaugura officiellement la convention. Cette inauguration fut suivie d'un mot de bienvenue par la Révérende Soeur Saint-Adelphe, supérieure de Saint-Michel-Archange. Prirent également la parole Soeur Joseph-Hilaire, présidente des archives médicales de la section des hôpitaux du Québec, et le docteur Margaret McGuire, présidente de l'Association Canadienne. Le Père Meehan prononça une conférence intitulée "Bonne Entente". Il traita de l'importance pour les archivistes d'hôpital de travailler dans une atmosphère de compréhension et de collaboration.

Par cette conférence prononcée d'abord en anglais puis dans un français digne d'admiration, le père Meehan inaugurait cette convention qui a revêtu un caractère spécial par son bilinguisme qui s'est poursuivi jusqu'à la fin de la convention.

Dans la même après-midi, le Dr Marcel Langlois, directeur médical de l'hôpital Saint-François-d'Assise, à Québec, exposa les raisons pour lesquelles l'archiviste médicale doit être considérée comme une professionnelle. Une conférence qui fut aimée de toutes. Cette première journée se termina par une réception à "La Tournée du Moulin" offerte par les archivistes du Québec. Par cette réception, chacune put goûter la chaude hospitalité française de Québec.

La journée du mardi 16 septembre se passa au Jeffery Hale. M. Georges Clare au nom de l'administration souhaita la bienvenue aux archivistes et puis l'assemblée générale de l'association dura l'avant-midi. Dans l'après-midi M. le notaire André Duval exposa clairement les responsabilités et devoirs d'un membre actif qui sont de collaborer activement au travail de notre association, de maintenir l'unité sur le but à atteindre, s'intéresser à tout, connaître la charte ainsi que nos devoirs et responsabilités en tant que membres de l'association. Nous devons être loyales envers notre organisation, reconnaissantes envers nos prédécesseurs, apprécier les services rendus et accepter des charges non rémunérées.

M. le notaire Henri Taschereau se fit l'interprète de M. Arthur L. Flemming, représentant légal de l'association pour les réponses de la boîte aux questions.

Cette journée se termina par notre banquet au Château Bonne Entente, présidé par le Dr Marcel Langlois. Le conférencier d'honneur, le Dr C. Alfred Martin, chef de service en neuro-psychiatrie à la Clinique Roy Rousseau, prononça une causerie des plus intéressantes sur le travail qui s'accomplit dans un hôpital et un bureau d'archives en regard du dossier. Le Dr Martin provoqua chez son auditoire une hilarité presque continuelle. Résumons sa pensée du dossier médical complet. "Le dossier complet est celui qui est signé dans le moins de temps possible, par le plus de monde possible et accessible le moins possible au moins de personnes possible." Avant de terminer cette soirée, le Dr Margaret McGuire remit officiellement la présidence à Frances Wilson.

L'hôpital Laval nous recut le mercredi 17 septembre. Après la bienvenue de circonstance eut lieu le forum général dont l'animateur était le notaire Henri Taschereau remplaçant le Révérend Père Hector L. Bertrand. Les membres du forum étaient le Dr Marcel Langlois, Owen Carter, avocat, le Dr Margaret McGuire, Geneviève MacDuff, Soeur Joseph-Hilaire, et Soeur Marie Iréna. Par ce forum très bien organisé et surtout très bien animé presque toutes et chacune purent obtenir réponses à leurs questions.

Nous nous permettons de dire que l'après-midi passée à Laval fut l'une des plus intéressantes sinon la plus intéressante. Au début, nous avons eu le privilège de visiter le département de recherches expérimentales. Ce sont les chiens qui servent dans ces recherches de cardiologie. Puis se succédèrent les conférenciers traitant de sujets aussi variés qu'intéressants et le plus souvent accompagnant leur conférence de films. Cette dernière après-midi se termina par une visite de la faculté de médecine à la Cité Universitaire Laval.

Le lendemain par une pluie douce, un ciel nuageux et un temps froid, nous faisions en bateau un pèlerinage à Sainte-Anne-de-Beaupré. Le groupe était un peu plus restreint étant donné que plusieurs avaient dû partir la veille. Néanmoins, toutes furent heureuses de ce petit voyage qui se termina par une visite au musée provincial et à la citadelle.

Nous tenons à remercier tous les hôpitaux de la ville de Québec pour la chaleureuse hospitalité témoignée à toutes les archivistes médicales du Canada. Cette convention fut un succès. Nous le devons à toutes celles qui ont travaillé pendant de longs mois à la préparation du programme afin qu'il soit pour toutes une source d'enrichissement et une occasion d'établir de nouveaux contacts entre les membres de notre association. ■

Bertrane Royer est étudiante archiviste médicale à l'Hôpital Général St-Vincent-de-Paul, Sherbrooke, Que.

At the Alberta convention: l. to r. N. V. Buchanan, Rossland; Murray Ross, Toronto; Irial Gogan, Calgary; Jeanie Clark, Edmonton; Margaret Street, Calgary; and Noreen Flanagan, Medicine Hat.

Associated Hospitals of Alberta

15th Annual Convention

ON October 21, 1958, close to 400 delegates, the largest assembly ever to attend a hospital convention in Alberta, were welcomed to Edmonton by Alderman Fred J. Mitchell, for many years a hospital trustee himself and a member of the board of trustees of the Alberta Blue Cross.

In extending greetings on behalf of the Alberta Association of Registered Nurses of which she is president, Margaret M. Street of Calgary stressed the need for close co-operation among the members of the health team, particularly among doctors, nurses and hospitals. Not only was this co-operation needed on the actual scene of patient care, Miss Street suggested, but it must be carried through into the activities of the professional associations at both the provincial and national levels. Greetings were extended by Dr. J. W. Macgregor of Edmonton, president of the Alberta Division of the C.M.A., and by Dr. W. Bramley-Moore of Edmonton, registrar of the Alberta College of Physicians and Surgeons.

Reports

A financial report for the year ending September 30, 1958, was presented by the secretary-treasurer, L. R. Adshead of Edmonton. Comparisons with the preceding year indicated that both income and expense had increased by approximately 40 per cent and that the association had operated within its budget. The balance sheet indicated that the organization was in a sound financial position.

Murray Ross

Chief Judge Nelles V. Buchanan of Edmonton reviewed the year's activities in his presidential report. The commencement of a government-sponsored, province-wide hospital insurance plan at the beginning of April, suggested the president, justified labelling 1958 as the beginning of a new era for the hospitals of Alberta. Judge Buchanan expressed the view that the insurance plan was a good one; extensive coverage was provided and the hospitals were assured of the recovery of reasonable costs of operation. However, it would not be possible to pass judgment upon the plan until all the evidence was in, he said. For the hospitals this would be when a final accounting and reimbursement for a year's operation was made.

The president referred to the close liaison and co-operation existing among the officers of the association and the Minister and officials of the Department of Health. The government, he said, needs the assistance of administrators and other experienced personnel in order to make its plan work. The hospitals, on the other hand, need the co-operation of the government so that they may receive funds in amounts sufficient to provide the services which are required.

A strong, united, vigorous and outspoken association, Judge Buchanan stated, provided the only effective means by which the hospitals could make their views known and is the means by which the proper balance can be maintained between the traditional objectives and *modus operandi* of hospitals and the interests of the Department of Health.

The president paid tribute to the outstanding service performed by Reg. Adshead (which brought an enthusiastic round of applause from the delegates) in discharging his duties as secretary-treasurer. Nevertheless, if the association was to achieve the maximum success possible, a full-time staff with the necessary facilities and equipment would be required.

By unanimous vote, the delegates subsequently endorsed the recommendations of the board of directors contained in the president's report for a greatly expanded program of association activities, and sanctioned the necessary amendments to the bylaws and approved of a membership fee structure to handle the additional cost.

Nursing Education

"The rôle of the University of Alberta in basic nursing education" was the subject of a paper by Dr. W. Johns, vice-president of the University, opening a symposium on nursing education. The general faculty council of the University appoints a committee on nursing education and also a board of examiners in nursing. The University is primarily concerned with educational standards and qualifications and is therefore interested in the

(continued on page 54)

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Alberta Convention

(continued from page 52)

program offered by each school of nursing.

After several frustrating experiences by other methods, the committee on nursing education had engaged a full-time advisor to schools of nursing. The objective of the program was not to withdraw approval from schools but rather to improve standards. In other words, to make "poor schools good and good schools better". The committee also hopes, Dr. Johns reported, that a conjoint examination will eventually be adopted for graduation from any school of nursing in the province and for qualification as a registered nurse.

Margaret Schumacher, advisor to schools of nursing, University of Alberta, Edmonton, spoke on the functions and activities of her office. So far a total of 24 visits, from one to five days' duration, had been made to the 12 schools of nursing. The objective of the program is to help clarify policy, etc., but not to actually execute any of the changes which are recommended.

A very clear and concise outline of the pilot study now being conducted by the Canadian Nurses' Association for the evaluation of schools of nursing in Canada was presented by Jeanie S. Clark of the University of Alberta Hospital, Edmonton. The objectives of the pilot study (see *Canadian Hospital*, April, 1957) is to determine whether or not Canadian schools of nursing are ready for an accreditation program, the basis on which such a program could be carried out, the procedures which should be followed, the personnel which would be required, and an estimate of the cost of a program. The general pattern being followed is that employed by the National League for Nursing in the United States. From the 96 hospital schools which volunteered, 25 have been selected for the study. Selection was made on a basis of geographical location, size, type of control, and nature of service available, in order to obtain a representative cross-section of hospital schools.

Drawing upon her own experience as a surveyor, Miss Clark outlined the extent of the intensive survey which must be conducted for each school. It was emphasized that the survey report only describes and does not evaluate the school. The evaluation is conducted by a board of review established by the C.N.A. which includes representatives of the Canadian Medical and Canadian Hospital Associations.

In addition to the C.M.A. and the C.H.A., the liaison committee includes representatives of the Canadian Public Health Association and the Canadian Association for Adult Education. The report of the pilot study's director, Helen K. McThalem, should be ready for presentation to the Canadian Nurses' Association in August 1959 and will be placed before the biennial meeting of the association for consideration in 1960.

Hospital Insurance

The earlier comments by Judge Buchanan concerning liaison and co-operation between the association and the government were echoed by the Honourable Dr. J. Donovan Ross, Minister of Health. Dr. Ross stated that the government was aware of the dangers inherent in government intervention in any activity; nevertheless, he urged constant vigilance by the people affected, in this instance the hospitals, to the end that government controls and the curtailment of individual liberties would be held to a minimum. Dr. Ross expressed gratitude for the assistance received from the association in the development and implementation of the insurance plan as well as for the co-operation of individual hospital administrators and boards. He briefly outlined changes in the system of payment for services and indicated that modifications would be made as required in order to make the operation of the plan as efficient and effective as possible.

Looking to the future, the Minister forecast the introduction of legislation designed to increase the facilities available for health care in the province. In particular, this legislation would be aimed at the construction of approximately 3,000 additional beds for nursing homes, the cost of which would be shared by the province, the municipalities, and the patient.

Following introductory remarks by J. D. Campbell, Director of the Hospitals Division, Dr. Ross, Mr. Campbell, and other officers of the Department of Health, formed a panel for a lively question and answer period during which many facets of the provincial plan were discussed.

Sectional Meetings

An afternoon was devoted to sectional meetings as follows: secretaries under the chairmanship of H. J. Peddie of Hanna, trustees under the chairmanship of J. E. Carlson of Vulcan, matrons under the chairmanship of F. McWhinnie of Wetaskiwin and chronic hospi-

(concluded on page 88)

Standing (l. to r.): S. M. Chapman, Lethbridge; W. Chessor, Lacombe; H. P. Wright, Calgary; L. R. Adshead, Edmonton; F. W. Lamb, Lethbridge; J. E. Carlson, Vulcan; and Dr. D. R. Easton, Edmonton. Sitting (l. to r.): S. V. Pryce, Calgary; Sr. Mary, Barrhead; Chief Judge N. V. Buchanan, Edmonton; and Sr. Alice Gauthier, Edmonton.

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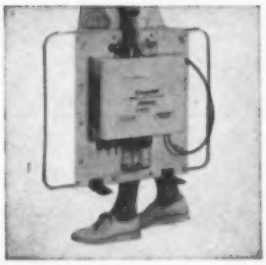

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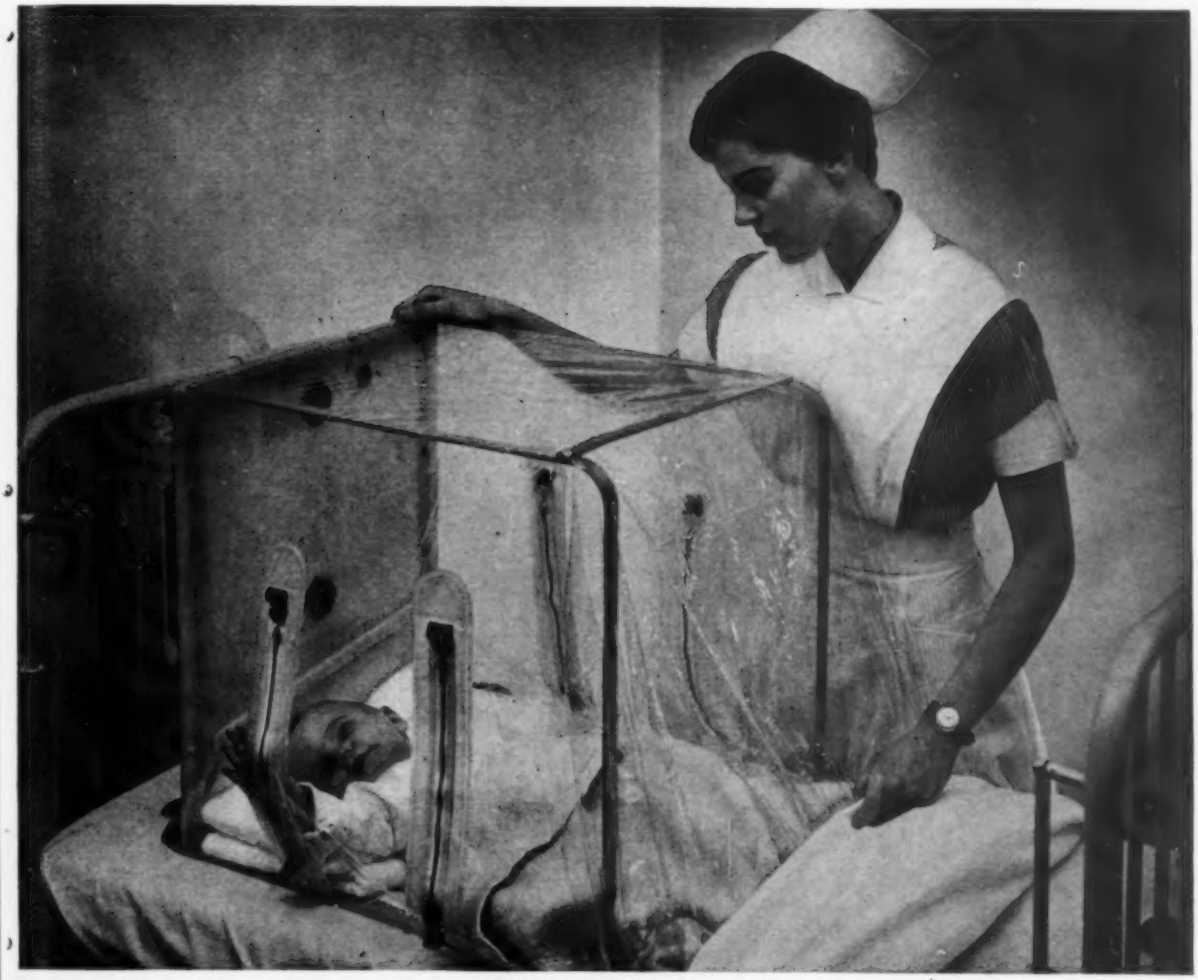

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Provincial Notes

British Columbia

Victoria's new Queen Alexandra Solarium for Crippled Children has been officially opened. The $900,000 solarium has a 96-bed capacity (it provides 80 beds at present) and replaces the Mill Bay solarium which had only 30 beds.

It has been decided that the Tranquille Sanatorium in Tranquille, which no longer acts as a sanatorium, will be transformed into a school for the mentally defective. The need for tuberculosis hospitals is not as great as it was. That is the reason for the change in this hospital, which looked after tuberculosis patients for 50 years.

It has been decided that Fort St. John needs a new general hospital. However, there is still the question of who will do the building. Offers to build a hospital here have been made by the Sisters of Providence (who would pay half the cost and would staff and operate the hospital) and by North Peace Hospital Improvement District No. 13. Plans for a hospital have already been prepared for the Sisters by architects Gardiner, Thornton, Gathe and Associates of Vancouver.

The contract for construction of a prosthetic services building at the Veterans' Hospital in Victoria has been awarded. The one-storey structure will be built on the grounds of the existing hospital and has been designed as the first part of an H-shaped building which will eventually be two storeys high. The new building will accommodate maintenance engineers and equipment from the hospital, and will house prosthetic services personnel.

Close to the end of 1958, Nelson's Kootenay Lake General Hospital was officially opened. The hospital has 134 beds, and was built at a cost of $1,890,000. Architects were Williams and Fairbanks of Nelson.

Alberta

The Coronation Municipal Hospital board has taken the first steps toward a new 25-bed hospital for Coronation. It has also been suggested that a 25-bed hospital for chronic patients be built close to the new active treatment hospital. Then all service facilities will look after both buildings. Total cost is estimated at $450,000.

Edmonton's Royal Alexandra hospital has a new look for the new year. Renovations to the old main building and construction of new buildings are being pushed ahead. New buildings are the nurses' residence and the now-completed cafeteria and kitchen building. And, construction of a $5,800,000 annex will begin in the spring. Chief architects are Rule, Wynn and Rule of Edmonton.

It has been decided that 30 hospital beds on the fifth floor of the Medicine Hat Municipal Hospital, Medicine Hat, will be opened. The reason? A substantial increase in the number of available nurses. Because of a staff shortage, 14 beds were closed down on the hospital's fourth floor last year. These will remain closed when the fifth floor wing is opened. The new year will also see the landscaping of the hospital grounds—with enlarged parking lots.

The village of Picture Butte has been set up as a municipal district, and the proposed construction of a 25-bed hospital there has received approval. This final approval follows much hard work by the Chamber of Commerce hospital committee formed in the spring of 1956.

A new general hospital is to be built in Willingdon. The 50-bed hospital will be run by the Sisters Servants of Mary Immaculate. Architects are Gardiner, Thornton, Gathe and Associates of Vancouver. The existing building will be converted into staff and sisters' quarters.

Saskatchewan

A new nurses' residence for the Leader Union Hospital in Leader was officially opened last November. The attractive residence has ten single bedrooms, two double bedrooms, a matron's suite, kitchenette, laundry and a large lounge. The total cost was about $70,000.

A 25-bed hospital is to be constructed in the northern community of Lac La Ronge. The new hospital, completely modern, will contain, in addition to hospital wards, space for doctors' and nurses' headquarters and laboratories.

Saskatoon's University Hospital was recently presented with a cheque for the purchase of a major piece of equipment — an oximeter recorder — to be used in heart diagnosis. This was presented to the hospital by the Saskatchewan Heart Foundation, in recognition of its having one of the most modern heart diagnosis and treatment departments in Canada.

Yorkton has now been assured that it will have a new hospital. Containing 150 beds, it will replace the present hospital which has 120. The new building will have four operating rooms, recovery area, and maternity ward with a division for premature cases, formula rooms, and a glassed-in children's area with 18 beds. There will also be a large x-ray room, proper laboratory facilities, emergency room, and much needed waiting and dressing rooms, as well as many other features now denied in the present building.

Approval has been granted for construction of a new 30-bed hospital in Wilkie. It will cost an estimated $300,000. Working drawings are now being prepared by the Saskatoon architectural firm of Webster, Forrester and Scott.

Manitoba

During a recent storm, rain swept through the front entrance and flooded the office, the operating room, and the doctors' offices of the Minnedosa District Hospital in Minnedosa. Water also came in through the roof, and holes had to be drilled in the ceiling so that the water could run off and then be swept down the halls and ramp and out through the basement. The health department and rooms where x-ray equipment is kept also got a share of the rainwater, but fortunately the equipment did not appear to be damaged. The walls and the ceiling took most of the beating.

The Portage District Hospital in Portage La Prairie is planning

a new paediatric wing, plus extension of its laboratory and x-ray services. Architect Kenneth Pratt of Winnipeg drew up preliminary plans for this 25-bed addition. The wing is expected to cost about $125,000.

Ontario

Construction of 18 buildings of the Ontario Hospital for Retarded Children at Cedar Springs on Lake Erie was begun late last year. The hospital will be similar to the one at Smiths Falls—with an initial capacity of 1,300 patients. Provision will be made for increasing the number of beds to 2,200. There will be administrative buildings, school, gymnasium, recreation room, central dining hall, kitchen, sleeping pavilions and bathhouses, as well as a medical, surgical and treatment building with beds for 400.

A 75-bed home for the aged is planned for the Muskoka district. The estimated cost per bed is $6,500.

The contract has been awarded for construction of an out-patient department and another patient wing for Scarborough General Hospital in Scarborough, an area of metropolitan Toronto. The five-storey structure was designed by architects Govan, Ferguson, Lindsay, Kaminker, Langley and Keenleyside of Toronto.

Plans for modification and additions to the Great War Memorial Hospital in Perth are final. These plans have been worked on for three years, but this is the first time that the hospital board has been able to satisfy all the departments concerned. The new addition will be on the site of the present hospital garden — there will be a special entrance for emergency cases.

South Peel Hospital in Cooksville has been open only a few months, but it is filled to capacity already. The board met to decide what expansion is needed most—a new wing or a nurses' residence. Now the hospital can accommodate only nine nurses.

A 375-bed addition for the Nora-Frances Henderson Hospital has been planned to provide emergency hospital facilities for Hamilton's quickly expanding mountain area. The cost is estimated at $7,000,000.

A new hospital for Manitouwadge—the Manitouwadge General Hospital—is planned at an estimated cost of $475,000. A $75,000 nurses' residence will be built later. A scale model of the building is to be on display at the Hudson's Bay store where citizens may come and look it over.

When the sod was turned for a 120-bed, $1,500,000 addition to Lindsay's Ross Memorial Hospital, it was the daughter of the chairman of the hospital's first board of governors who did the job. Ethel Flavelle, daughter of J. D. Flavelle, was assisted by Premier Leslie Frost on this important occasion—and another major event in the hospital's history was recorded.

In a lovely wooded setting, Thistletown's hospital for emotionally disturbed children was officially opened. The hospital is equipped with special furniture and steel mesh screens, designed to keep children from hurting themselves — drawers cannot be taken out of dressers, beds are fastened to the floor. So far, it has cost the Ontario government $1,260,000 to acquire the former isolation wing of the Hospital for Sick Children and another $800,000 to alter it. A new building with gymnasium and swimming pool will be ready next fall. The plan is that each child will be studied for a month to see if the hospital program will benefit him; then there will be intensive treatment for a period of six months to one year. The youngsters there will not lose touch with the world; they are given parties and are taken to outside parks and recreational spots as often as possible.

The plans for the St. Francis Memorial Hospital at Barry's Bay have been approved. It is hoped that the most modern 31-bed hospital possible will some day serve the population of Barry's Bay and District.

The new Milton District Hospital, Milton, is under way. The climax of 4½ years' planning and work, the new hospital will contain 62 beds. It was designed by Clare G. MacLean of Toronto.

Three suggestions about how best to expand Trenton Memorial Hospital, Trenton, were placed before the board—two 50 foot wings on each end of the present building, one wing 100 feet long extending north from the east end, or a whole new floor. The present 74-bed hospital was built in 1948. Now it has become so busy that private rooms must be converted to semi-private and corridors used to handle the large number of patients. The proposed addition will provide increased accommodation and extra services.

The proposed new addition to Petrolia's Charlotte Eleanor Englehart Hospital is to contain 41 beds. The new wing will be built to the south of the present building and will be two storeys high. The upper storey will contain maternity wards; two-bed semi-private rooms and wards will be on the ground floor; and in the basement will be a dining room, kitchen and classroom for nurses' aides.

A new 32-bed hospital — the Kemptville District Hospital — is planned for Kemptville. Architects Balharrie, Helmer and Morin, Ottawa, designed the building which will cost an estimated $415,000.

Kincardine General Hospital in Kincardine will have an addition and alterations which were designed by Douglas E. Kertland of Toronto. The extension, a basement and two storeys, will house operating room and wards.

The board of Palmerston General Hospital in Palmerston looks forward to the construction of a new wing and improvements in the existing hospital building. The new wing will replace the old annex which has given good service but which now must be replaced. An expenditure of $150,000 is anticipated.

The medical staff at the Greater Niagara General Hospital in Niagara Falls is in favour of establishing a dental department in the new building. The department was requested by the Niagara Falls Dental Society so that patients requiring special treatment might be taken there.

Quebec

A department of general practice has been set up at Montreal's Queen Elizabeth Hospital. Its members, with the rank of attending staff, hold clinics in the out-patient department. The medical staff of the hospital suggested this department and were responsible for its being set up.

In a unanimous vote, the NDG Kinsmen Club decided to make the equipping of this hospital's emergency department their major project. They have guaranteed $15,000, an amount expected to cover the cost of operating tables, examination tables, lights, chairs, and other necessary furniture. When all work on the hospital is finished, the Queen Elizabeth will

(concluded on page 84)

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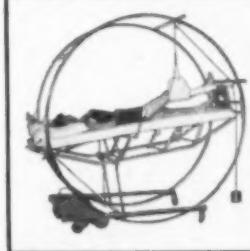


Notes on Federal Grants

Construction

A grant of $118,000 is to go towards providing space for 60 additional beds and diagnostic facilities at the Victoria Union Hospital, Prince Albert, Sask.

Kamsack Union Hospital, Kamsack, Sask., will receive $15,000 for the building of a nurses' residence, and $7,000 for an extension to house eight beds for patients from one to six years of age. A playroom is to be included, as well as a utility basement to provide a dining room for the staff. The nurses' residence, when completed, will accommodate 21 nurses in its one and a half storeys.

For construction of a chronic care hospital with 46 beds, four nurses' beds and an out-patient department, the Hospital La Visitation, Montreal, Que., has been allotted $74,420.

An out-patient department and 209 beds for the chronically ill will be provided at the Institut Marie-Clarac, Montreal, Que., with a grant of $428,500.

At Val d'Or, St-Sauveur Hospital will be aided by a grant of $33,484 to go towards constructing a 46-bed nurses' residence.

Jean-Talon Hospital in Montreal, Que., will receive $581,413. About $525,413 of this is to help with the cost of a wing which will house 202 beds, 47 bassinets, an out-patient department and teaching facilities for the nurses at the hospital. A further 28 beds will be accommodated in an additional storey, to be helped financially by $56,000 of the grant.

A new maternity unit at Highland View Hospital, Amherst, N.S., will be assisted by a federal grant of $9,000. The new building will make 10 additional beds and 14 bassinets for the hospital, along with formula and case rooms.

St. Boniface General Hospital, St. Boniface, Man., has been granted $18,997 to aid in renovation and remodelling a part of a building—to be used as a residence for 30 interns.

To go towards the cost of enlarging a medical nursing unit at Wawanesa, Man., is a grant of $7,470. This unit will contain space for four beds, three bassinets, a community health centre, a case room, doctor's office and laboratory.

Diagnosis and Research

Notre Dame Hospital, Montreal, Que., will receive $228,658 towards the purchase of equipment for the x-ray department, including diagnostic and therapy equipment.

McGill University also receives funds, $20,089, for aid in a research project called "Combined Investigation into Maternal Protein". This project will be carried on in the department of obstetrics and gynaecology at the Royal Victoria Hospital, Montreal, and the Gross Anatomy Division of McGill's department of anatomy, under the leadership of Dr. G. B. Maughan, and Dr. J. Langman, of the university's teaching staff.

Mental Health

A grant of $9,200 will assist in a comparative personality study of successful and unsuccessful group therapists at the Verdun Protestant Hospital, Verdun, Que. To be conducted by Dr. E. G. Poser, director of the psychology department at this hospital, and associate professor at McGill, the study is to examine the personalities of therapists and the manner in which they affect the success of their work in group therapy. The money will go towards costs of salaries and necessary equipment.

Public Health

For research into a program of home medical care, the Winnipeg General Hospital, Winnipeg, Man., has been awarded $11,950. Studies are to be made of the advantages and difficulties of a program to improve care of chronically ill patients and bridge the gap between in-patient and ambulant out-patient services. Personnel needed will include three physicians on a part-time basis, a nursing co-ordinator, or a social worker and a secretary. Community services, such as the V.O.N. and the Canadian Arthritis and Rheumatism Society will be called upon.

For the establishment and maintenance of a model child health service at the University of British Columbia, Vancouver, B.C., a grant of $9,500 has been made. The project, a collaborative effort by the university departments of paediatrics and preventive medicine, will be directed by a committee which includes the assistant provincial health officer, the senior medical health officer of the Greater Vancouver Metropolitan Health Committee, and the professors and directors of the university departments and schools involved. This centre, for children of undergraduates of the university, will do research on growth and development, study methods of better integration of public health services with those of private practitioners, and serve as a teaching centre for nurses, medical students and social workers.

The Extension Course in
Hospital Organization and Management

All those interested in enrolling in the 1959 class of the extension course in hospital organization and management should submit applications not later than March 31st. The course commences in early September. Because the demand for enrollment continues to be heavy, assurance can not be given that applications arriving late will be considered.

The two year program is now in its eighth year, and the certificate of graduation given by the Canadian Hospital Association has been granted to 294 persons. Those enrolled in the course spend eight months each year studying lessons at home and preparing assignments. This period is followed by an examination and a four-week intramural summer session at a specified Canadian university.

Information and application forms may be obtained by writing to: The Secretary, Committee on Education, Canadian Hospital Association, 280 Bloor Street West, Toronto 5, Ontario.

Book Reviews

DOCTOR SQUIBB, by Lawrence G. Blochman. Published by Simon and Schuster, New York, N.Y., 1958. Pp. 371. Price $5.00.

Described as "the life and times of a rugged idealist", this story tells of Dr. Edward Robinson Squibb — one of the founders of modern medical chemistry. Throughout his life he fought to have impure drugs banished from the market, becoming one of the first to work for the establishment of a modern pharmaceutical industry as well as a federal food and drug act. In an effort to push closer to a realization of his ideals, he began his own publication, *An Ephemeris*, in which he evaluated new drugs and techniques and slapped down quacks.

One of his greatest achievements was in the field of anaesthesia. He developed a method of distilling pure ether with steam, and also invented a mask by which anaesthetic could be effectively administered.

Quotations from the doctor's own diary add a sense of life and realism to the book; it is in these moments that we find Edward Squibb, the man—a devoted husband and father. His personal charm, his fire and enthusiasm are as important in the book as his fine scientific mind. Here the man is allowed to share the spotlight with the doctor. The result is very interesting indeed.

PATIENTS ARE PEOPLE, Second Edition. By Minna Field. Published by the Columbia University Press, Morningside Heights, New York, 1958. Distributed in Canada by the Oxford University Press, Toronto. Pp. 280. Price $4.75.

In the midst of advancing medical achievements lies still the problem of prolonged, chronic illness. This is what the author faces as she probes into the fears and uncertainties that plague people suffering from long-term or incurable diseases. She feels that these patients must be encouraged to return to the social world outside the hospital as soon as possible. Hence, they need medico-social help, need sympathetic people to help them with their problems and understand them as human beings.

This book offers hope to patients with prolonged illnesses, as well as to their friends and families. For no matter how sick he may be, the patient still retains his value as an individual.

PERSONNEL PROGRAM GUIDE, for Nursing Education and Nursing Service Agencies. By Ruth V. Johnston, Ph.D. Published by W. B. Saunders Co., Philadelphia and London, 1958. Pp. 137. Price $2.75.

This small paper-backed volume is a book with a purpose. It grew out of the author's realization that a guide to help meet nursing personnel problems was necessary. If such problems are eliminated—and many of them can be—both students and employed nurses will become more efficient at their jobs. This book looks quickly at the question, offering suggestions rather than rules. It leaves the impression that a sound and well-organized personnel program is well worth any time and effort it may cause.

ANATOMY AND PHYSIOLOGY, by Irene McKean, B.S., R.N. Published by the W. B. Saunders Co., Philadelphia, Pa., 1958. Pp. 193. Price $3.00.

This is a compact paper-backed laboratory manual and study guide, prepared by the instructor in biological sciences at Fairview Hospital School of Nursing, Minneapolis, Minn. Its purpose is to help students to learn, with diagrams and question forms, the facts and principles of the subject. It is geared for use with laboratory material which does not require elaborate preparation.

REPORT OF STUDY TOUR OF HOSPITALS IN THE GERMAN FEDERAL REPUBLIC. Published by the International Hospital Federation, London, England, 1958. Pp. 89.

Last summer about 200 members —from 20 countries—of the International Hospital Federation took a study tour to see what Germany had accomplished in recent years in hospital construction and equipment. This is their informative report. Ten hospitals—nearly all of which had been opened during the past two or three years—were visited, and the report contains descriptions of them along with information on the number of patients treated and building costs. Under the section dealing with the hospital under the Health Services plan we discover that general hospitals in Germany have a capacity of 6.5 per 1,000 population and that the favoured construction is the multi-floor, or vertical block system, to give economy in operation and concentration of treatment facilities. About 80 per cent of all hospital patients are treated in third-class accommodation, *i.e.*, that for patients covered by social insurance. These are but few of the interesting facts on hospitals in Germany that can be gleaned from this paper-backed booklet.

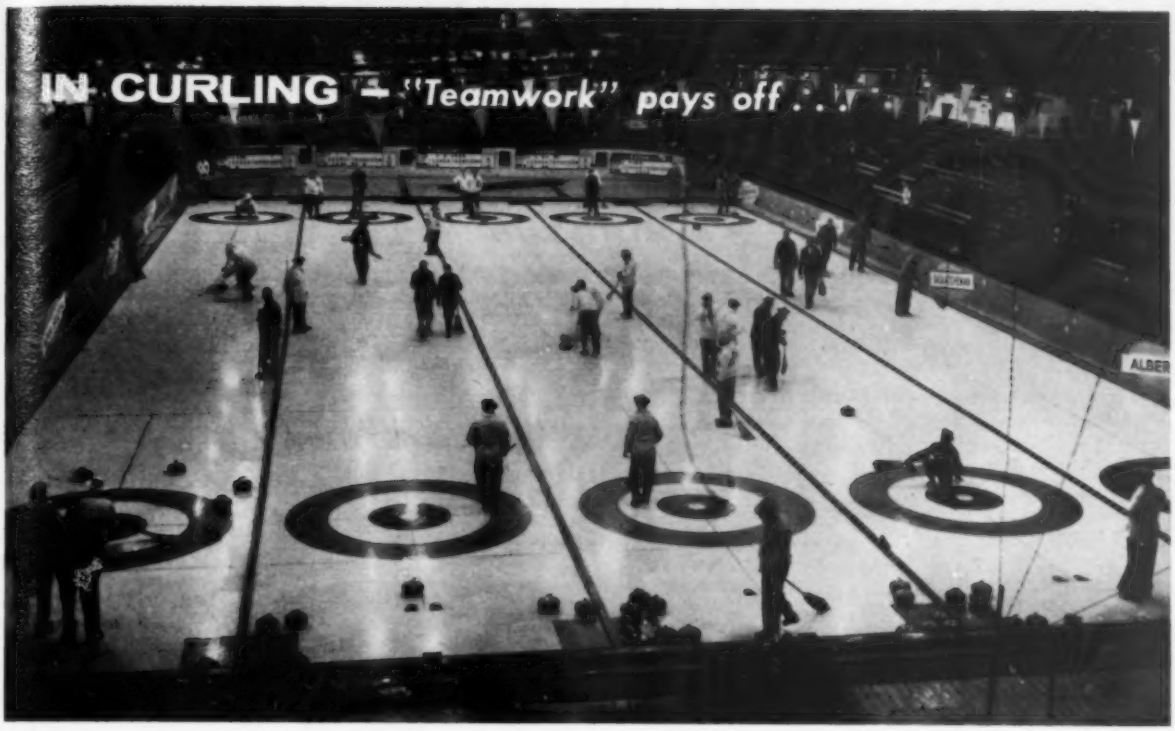
HOSPITAL AND COMMUNITY, a History of the Royal Melbourne Hospital, by K. S. Inglis. Published by the Melbourne University Press, Melbourne, Australia. In Canada by the Macmillan Co. of Canada Limited, Toronto, Ont. Illus. Pp. 226. Price $5.00.

The Melbourne Hospital, founded in 1846, is one of Australia's most prominent. This book recalls its humble beginnings, and traces its development in bright and lively terms, to the modern teaching and research institution it is today. Always brought to the reader's attention is the ideal of community service behind the project—an ideal which was more and more realized as the hospital grew up from its original dark and dingy wards. This is the story of its growth.

National Health Week

Do you take as good care of yourself as you do of your car? If not, you may be sorry—neglected health can lead to costly repairs. This is the message of the Health League of Canada, as it prepares to sponsor National Health Week (February 1-7, 1959) for the 15th time.

Citizens are requested to consider carefully what good health means. They can help promote a healthy nation for the future by having regular medical and dental check-ups and by seeing that their children are immunized. Medical science has the power to control many diseases, but a great responsibility rests on the public. National Health Week is designed to emphasize that responsibility, and make Canada a health-conscious country.



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Twenty Years Ago

From The Canadian Hospital, January, 1939

It was a shock to everyone to hear of the December disaster at Sydney Mines. The lot of the miner has never been an easy nor a lucrative one and this misfortune dealt a hard blow to the families of this district. For many days the press and radio kept Canada and the United States closely in touch with developments in this far-away corner of the continent. But little, if any, news filtered through of what went on in the small 40-bed Harbour View Hospital there during the first hectic forty-eight hours.

The reading public seldom learns of the real drama "behind the scenes". They seldom hear of what goes on immediately following that first breathless telephone warning to the hospital—the orders to the operating room, the "on duty" call to all nurses, the hurried survey of available beds, the check on sterile goods, the call to the engineer for steam, the unearthing of cots and stretchers. Nor does the public know of what really goes on after that first group of victims arrives —the selection and rushing of the more serious ones to the operating room, the quick decisions which must be made, the temporary treatment in the corridor to those bleeding or in great pain, the fear lest the supply of dressings, or of glucose, of A.T.S. give out. In a few moments the whole hospital organization like one big machine, must be thrown into gear, and brought into full and efficient action—"hours off" are forgotten; the eight-hour day becomes sixteen, twenty-four, thirty-six. If the public could only be given the inside story of the hospital's participation in such tragic incidents, the real significance of the hospital, its value to its community, would be realized as never before.

* * *

Installation of coal-burning cookery units has just been completed at the Wellesley Hospital, Toronto. Replacing gas, the units are stoves constructed on the "heat storage" principle. Heat is produced by sustained, slow and complete combustion and is retained until required in great heavily-insulated castings within the stove.

A Dietary Manual

(concluded from page 49)

of the sheet; if certain micronutrients were inadequate, a statement should be made to that effect.

The new diets were returned to the dietetic committee of each hospital to be approved and ultimately discussed with the medical committee for their approbation.

Back in her own home territory, the therapeutic dietitian, together with her committees, had to make a few more decisions before the diet manual could be assembled to meet the specific needs and policies of the hospital, namely: What material should be included in the manual?

A study of various and excellent manuals supplied these answers:

1. Name of hospital (committees) is desired.
2. Preface (on this page, we stated the purpose of our manual).
3. Acknowledgments (food values, sources used, et cetera).
4. Instructions regarding diet orders, and policies of dietary departments.
5. Table of contents.
6. Diets (number kept as low as possible).
7. Tables.
8. Glossary of diets. (This is peculiar to our manual. Less common diseases not found in the diet manual are listed together with the suggested diet to be used).
9. Index.

The diet manual in its tentative form made its debut in a sturdy and neat folder 8½ x 11, and was mimeographed in the hospital. Information about the sizes, format, type paper and page lay-out are well described in *The Guide to Diet Manual.*

A dietary manual should be revised frequently to keep abreast of scientific findings in the medical and nutritional fields. Our manual was not revised until 1957 and was presented to the members of the medical staff early this year. The revision was the fruit of the experience gleaned from the use of the first manual; the study of two excellent books, *Therapeutic Nutrition,* by Pollock and Halpern and *The Hand Book of Diet Therapy,* by Turner; as well as reference to the *Guide to a Diet Manual;* and the wonderful co-operation of the doctors in using the diet manual.

The "new look" of the manual consisted in still greater simplification by the reduction of ten diets which were relegated to the glossary of diets and the addition of a few more diets. Page lay-outs were changed, and a stiffer more attractive cover was used.

Thus we met the challenge. We needed a manual of our own to clarify our policies, to simplify diets, and the work in the dietary department. It does just that.

We deemed it a great necessity for the smooth running of the dietary department, and for union among nurses, doctors, interns and dietitians. Today, we accept it as a matter of course, a factor which we cannot do without, one promoting a happy co-operative team of workers, all revolving around the one person, the patient. ■

The Extension Course for Training Medical Record Librarians

Enrol Early for 1959

Until March 31st applications will be accepted for the 1959 class of the extension course for training medical record librarians. The course will commence in late August. This will be the seventh group of students to undertake the training sponsored by the Canadian Association of Medical Record Librarians and the Canadian Hospital Association. Persons with junior matriculation, or the equivalent, who are already employed in the medical record department of a hospital or clinic are eligible for enrollment. Either one or two years may be taken. A certificate of accomplishment is awarded by the Canadian Association of Medical Record Librarians upon the successful completion of each year. A home-study or winter session of eight months is followed each year by a 4-week intramural summer session in a Canadian hospital approved for the purpose.

Information and application forms may be obtained from: The Secretary, Committee on Education, Canadian Hospital Association, 280 Bloor St. West, Toronto 5, Ontario.

Here and There . . .

Africa's Floating Laboratory

A new river launch built for medical research in tropical Africa was demonstrated recently off the coast of England. The *Lady Dale* will serve as a floating laboratory and means of transport for use by the Medical Research Council's laboratories in the Gambia.

The launch will have its base at Bathurst at the mouth of the River Gambia. It will sail from there to the subsidiary field laboratories at Keneba, about 70 miles up river, and to other parts of the territory along the river where laboratory facilities would not otherwise be available. The *Lady Dale* can accommodate four research workers in its very modern laboratory.

The Medical Research Council's laboratories in the Gambia were originally formed as a subsidiary of the Council's Human Nutrition Research Unit in London, but became independent in 1953. Its research program is concerned mainly with parasitic diseases, primarily malaria. Most of the laboratory investigations are carried out at the main station, on the coast at Fajara, where there is a small hospital for the treatment of patients. With the addition of the *Lady Dale*, the scope of the Council's research program will be greatly extended. —*U.K. Information Services.*

New Nurses' Home for St. Bart's, London

A 12-storey nurses' home of reinforced concrete and brick is to be built on a site adjoining St. Bartholomew's Hospital, London, England. Costing some £386,000, it will include a swimming pool, recreation hall, sitting rooms and accommodation in single rooms for 135 nurses. The modern building will also have a pleasant roof garden.—*Hospital and Health Management.*

Construction in Australia

A new Royal Children's Hospital is presently under construction in Melbourne, Australia. The first stage was completed in February, 1958 when the new nurses' home was built. The second stage, recently begun, will provide the main ward block building; staff residences will be built in the third and final stage. The main block will be an H-shaped building which will accommodate 374 patients.

An interesting feature of the hospital is the kindergarten and nursery where mothers attending the out-patient department with their children will be able to leave their other children while they are away. Bedroom accommodation will also be provided for mothers, so that in special cases they may live in the hospital and care for their children, thus learning what to do when their children leave the hospital.

* * *

In Perth, a school of medicine has been set up by the University of Western Australia. The Clinical School Building was officially opened in April of last year before all the new buildings were complete. This part of the school has already been in use for one academic year, since several students from Western Australia returned from their studies in Adelaide to take their final year in Perth. Four hospitals have been designated as teaching hospitals —The Royal Perth Hospital, the King Edward Memorial Hospital, the Princess Margaret Hospital, and the Freemantle General Hospital.—*International Hospital Federation News Bulletin.*

Sole Zoonoses Centre Receives Grant

The Pan American Zoonoses Centre, established in 1956, has recently received a grant from the Rockefeller Foundation of some $10,000 to help further the battle against the zoonoses in the Americas. The zoonoses—those diseases which are transmitted to man from animals—have only recently begun to receive strong attention from public health workers, although there are over 100 of these long neglected diseases.

The centre, located in Azul, Argentina, is 185 miles south of Buenos Aires and as the only institution of its kind is hailed by health officials everywhere as a landmark in public health administration. Services such as training, consultation, field demonstrations, confirmatory diagnostic tests, and research are all carried on by the centre.

At present the centre is concentrating on work on rabies, brucellosis and hydatidosis. Work in the virus encephalitides, anthrax, leptospirosis, bovine tuberculosis, psittacosis, trichinosis and salmonellosis will be increased as the centre's facilities permit. — *Pan American Sanitary Bureau.*

The only people who never fail are those who never try.—*English Digest.*

The Lady Dale.

With the Auxiliaries

Alberta's Auxiliaries Meet

In October of last year many eager women rushed to Edmonton for the tenth annual convention of the Associated Auxiliaries of Hospitals of Alberta. In addition to collecting an impressive $31,500, the auxiliary members throughout the province had contributed a great deal to hospitals during 1958 — an organ, television sets, baby conveyors, layettes, a heart catherization machine, bed lifts, et cetera. They also helped furnish patient rooms, nurses' homes, and waiting rooms.

An important moment in the convention came with the announcement of the bursary and scholarship winners. Beverley Young, who graduated from Lethbridge Municipal Hospital, will receive the first annual bursary of $200 given by the Associated Auxiliaries of Hospitals of Alberta for further training in psychiatric nursing. Miss Young is now at the Ponoka Mental Hospital in her home town of Ponoka. E. Lynne Millar, R.N., was the winner of the second annual Margaret E. Hamill Memorial scholarship. Miss Millar, who is from Mercoal, Alta., trained in the Calgary General Hospital and is now taking a post graduate course in teaching and supervision at the University of Alberta.

"What is the Future Potential of a Hospital Women's Auxiliary?" This was the title of a very interesting and lively panel discussion. When it had ended, it was clear that everyone feels auxiliaries are here to stay. After this there was more spirited conversation, for a workshop was held. Delegates broke up into groups of ten to talk over some problems about auxiliaries—*e.g.*, the definition of an active member, how to make inactive members active, the relationship between auxiliary and hospital board, and how an auxiliary can attract new members. After an hour of this, each group presented its findings to the others. A very satisfactory session — and convention!

The following are the officers for the new year: *past president*—Mrs. E. Wershof, Edmonton; *president*—Mrs. A. W. Hardy, Edmonton; *1st vice-president*—Mrs. E. P. Richardson, Calgary; *2nd vice-president*—Mrs. B. I. Love, Lamont; *treasurer* — Mrs. W. Hay, Lethbridge; *corresponding secretary*—Mrs. P. A. Rooney, Edmonton; *recording secretary*—Mrs. L. Lewis, Medicine Hat.

Take Your Choice

The auxiliary of the Montreal General Hospital, Montreal, Que., offers a variety of jobs to all interested volunteers. Clinic volunteers greet and direct patients, help keep records and make appointments. In the occupational therapy clinic volunteers help with diversional therapy — knitting, weaving, sewing, woodworking — designed to help develop muscles. The hospital plants are not forgotten, and volunteers donate a few hours a week to keeping them watered and green. Volunteers help with routine clerical duties, place magazines in waiting rooms every week and run the patients' library. They push the travelling wagon, with its cosmetics, stationery, candy, and knick-knacks, to every hospital floor once a week. And they work in the hospital's Hospitality Corner, a combined shop and snack bar. The auxiliary has stocked the shop with unusual and delightful items which tempt the visiting shoppers.

Hand in hand with the auxiliary works an eager crew of volunteers, doing its part to contribute to the hospital's success.

Donors' Hall

In November of last year at Toronto's New Mount Sinai Hospital, a donors' hall and commemorative cabinet were dedicated. Here those who have contributed to the hospital building fund, as well as future contributors, are honoured. At the same time, rotating pages of two illuminated volumes began acknowledging women's auxiliary subscriptions for special equipment and life membership.

In the cabinet, the donors' names are inscribed on embossed metal plates, with the name of a metal following each name to indicate the donation — *e.g.*, bronze ($500-$1,499), silver ($1,500-$3,499), et cetera. At the time of dedication, 1,600 names were placed in the cabinet; in time it will accommodate as many as 8,000.

Bazaar Bustle

The annual bazaar of the junior auxiliary to the Royal Jubilee Hospital in Victoria, B.C., featured tasty turkeyburgers. As soon as visitors had consumed these, they lost no time in touring the various exhibits. A popular spot was the gift stall which offered many Christmas ideas — mink-trimmed golf tees, gilded, jewelled hammers, hand-towels decorated with bells, bows, and holly. There was a doll stall, popular with the mothers, and a home-cooking stall, which was sold out shortly after the bazaar began. A stuffed animal counter attracted crowds, and garden plants were an extremely popular display.

While all this went on, sandwiches and cakes were being eaten in the tea rooms—a pleasant rest from some equally pleasant shopping. The eager visitors spent $3,400, providing a well appreciated Christmas gift for the auxiliary and the hospital.

Penticton Parade

A musical parade of interesting events from the "gay 90's" to the present was written especially for production at the Jubilee Ball, sponsored by the junior auxiliary to the Penticton Hospital, Penticton, B.C. The show featured songs and dances popular over the years, and starred auxiliary members.

Penticton's jubilee year also set the theme for decorations at the dance. Murals, copies of authentic early-day pictures taken in the city and neighbouring district, drew everybody's attention. Dance novelties, also keyed to the general theme, were handed out to guests. Proceeds from this popular event went toward the balance owing on the portable x-ray machine which the auxiliary had donated to the hospital.

Such A Sale!

There was something for everybody at the Thrift Shop Sale sponsored by the ladies of Kitimat Hospital, Kitimat, B.C. Members admitted that their sales (they had a similar one in the spring) mean lots of work, but they offer good times too. The money raised from both sales went toward the auxiliary's special project—the purchase of equipment for the play therapy

(concluded on page 84)

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B.C.H.I.S.

(continued from page 37)

Quite obviously, as part of the responsibility assumed through its agreement with participating provinces, the federal government has a responsibility to make certain that its legislation and the regulations thereunder are clear-cut, workable, and geared to the requirements of provincial hospital programs.

Provincial governments have certain basic responsibilities too. If their hospital insurance plans are to be successful, it is essential that they define policy clearly and concisely in legislation, regulations, and when necessary, policy directives; and then entrust the administration of their hospital insurance program to capable administrative staffs. In addition, each provincial government faces the trying responsibility of determining just how much its residents can afford to spend on hospital care. It is not always possible to provide hospitals with all the money they feel they need. This problem was well summed up by an eminent doctor at an advisory meeting when he stated that, while there may be almost no limit to the amount of money that could be well spent on hospital care, there is a definite limit to the amount of the people's income that can be spent on hospitalization without impairing other equally essential services. A proper balance must be maintained. It would serve little purpose if hospital costs went so high that medical care, education, or essential municipal services suffered. In the words of the German philosopher, Hegel, "Any extreme brings about its own negation."

Within the framework of responsibility for policy and financial decisions, the provincial governments have another responsibility—to respect and foster, to the greatest extent possible, the autonomy of the local hospital boards and encourage the growth of the community hospitals.

People sometimes ask whether the community has any real responsibility under a provincial hospital insurance program. They forget that their hospital is dependent on the community for its very existence. The citizens of the community initiate hospital planning and construction, and participate actively in the management of their hospital afterwards, regardless of whether it is owned by a municipality, a district, or by a non-profit society; even church-owned hospitals usually have substantial community representations on their boards.

Probably the most important part of the community's responsibility is membership on the governing board, in which is vested responsibility for the entire operation of the hospital. The hospital board and administrator have indeed a difficult time in endeavouring to balance the many and sometimes conflicting demands of patients, doctors, community organizations, and so forth, with the available income of the hospital. The establishment of a province-wide hospital insurance service is certain to benefit hospitals greatly by providing an assured source of revenue and making possible a steady extension and improvement of services. This has been amply demonstrated in Saskatchewan and British Columbia. On the other hand, such a program may well carry with it additional and sometimes unreasonable demands for services or other concessions because people so often assume that governments somehow have an unlimited source of money. They cannot keep in mind the obvious fact that the money a government spends comes from the people themselves. In addition, it is inevitable that the development of a hospital insurance service under the federal-provincial program will somewhat limit the scope of authority of hospital boards and hospital administrators, since so much of the hospital's income will be derived from the hospital plan. This is something that is not peculiar to the hospital field. Whenever a group of people combine for mutual protection or provision of joint services, there is bound to be some lessening of the freedom of individual action. There must be basic requirements that apply to all, and that benefit all. A hospital board has the responsibility of ensuring that the funds entrusted to it are spent in the best interests of patient care. Often the board has to evaluate and modify requests for additional services and equipment so that the over-all financial operation of the hospital can be kept in proper perspective.

I know a good many hospital boards who face up squarely to their problems. On the other hand, I occasionally meet a hospital board who make unwise concessions because they are apprehensive of offending their employees or their medical staff. Not long ago I reviewed a very elaborate plan for a nurses' residence and pointed out to the hospital board that there was a great deal of unnecessary space allotted to rarely used facilities. The chairman of the board later admitted that the board felt the same, but had referred the plan to the Hospital Insurance Service, as they did not wish to be too abrupt with key personnel who had sponsored the plan. They had assumed that the Service would cut it down to proper size. Similarly, while the hospital board and the hospital administrator are responsible for ensuring the best possible care for the patients, they have an equal responsibility to avoid the costly duplication of existing services merely to have some facility readily available at their hospital. I recently heard of a western United States' city in which the hospitals had a total of nine electro-encephalographs, although three or four would have been ample to serve the community. I do not know whether the provision of those facilities resulted from the demands of medical staffs, sponsorship of well-meaning but not well informed community organizations, or the hospitals' desire for empire building. In any event there can be no doubt that when costly and complicated diagnostic treatment facilities are used only to a fraction of capacity because an unnecessary number are operating, the patients and the people themselves pay for the extravagance either through unnecessarily high hospital bills or through being deprived of some other essential service.

Recently I heard a professor of psychology say that one of the problems in hospitals is that doctors have more authority than responsibility. I believe that the responsibility exists, but probably has never been fully defined or acknowledged. Doctors are confronted with many pressures and many demands. It is most natural that some, in their concern for their patients, may desire to have readily available at all times, and sometimes in all hospitals, the very latest in diagnostic and treatment measures, costly drugs and so forth. Understandably they may become impatient if they feel

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U. of T. Hospital Administration Students

Pictured here are students in the University of Toronto's hospital administration course during a recent field trip to the headquarters of the Workmen's Compensation Board. Seated l. to r. are: Dr. L. M. Davey, claims division, W.C.B.; Dr. H. J. Bright; Dr. J. D. Medhurst; C. E. Dosdall; R. E. Builder, assistant professor in hospital administration; J. J. Segalla; A. R. Thorfinnson. Standing, l. to r.: C. Ferguson, claims officer, W.C.B.; E. N. Stefanuk; A. B. McCartney, medical aid officer, W.C.B.; D. P. Fish; W. Mattersdorff; Dr. Mac Hattie; J. E. E. Osborne; H. H. Mullins; Dr. Donald Gee; and J. R. Haslehurst.

S.H.S.P.

(continued from page 41)

said: "Of course, our immediate goal is to cure the patient of his illness or injury; but in curing him we should also help him understand why he became ill, what he can do to prevent this same thing happening again." Some of you will go even further than this. You will examine your hospital to see whether it can be one of the facilities in the community for the development of preventive programs, health education, and so forth. You will also have looked at the other end of the disease process—if complete cure cannot be achieved, what can be done to rehabilitate the patient to his maximum capacity so that he will be able to take his place in society and not need continued health care. And you will have carefully studied the question of how the hospital program can be integrated into other programs to achieve these ends. In short, you will have examined how your hospital, in your community, can so order its affairs that it strives for the goal of making our people so healthy that someday very few (if any) of us will be needed.

What has all this to do with the relationship of government to hospitals and, more important, what has it to do with a hospital insurance service?

We could be very short sighted and say that the only purpose of a hospital insurance program is to meet the costs of providing freely available hospital care. We could then postulate that its main purpose is to spread the cost of care over the whole population so that no one suffers because he cannot pay what have now become sizeable costs. Fundamentally, this is the short sighted view. I would suggest, however, that there is a long-term view which is floating around in all our minds but is not often concretely expressed.

It is perhaps trite and redundant to remind you of two things —(1) our society is becoming increasingly interdependent and complex, and (2) as this interdependence and complexity increase we have to adopt organizational methods which will permit us to function effectively.

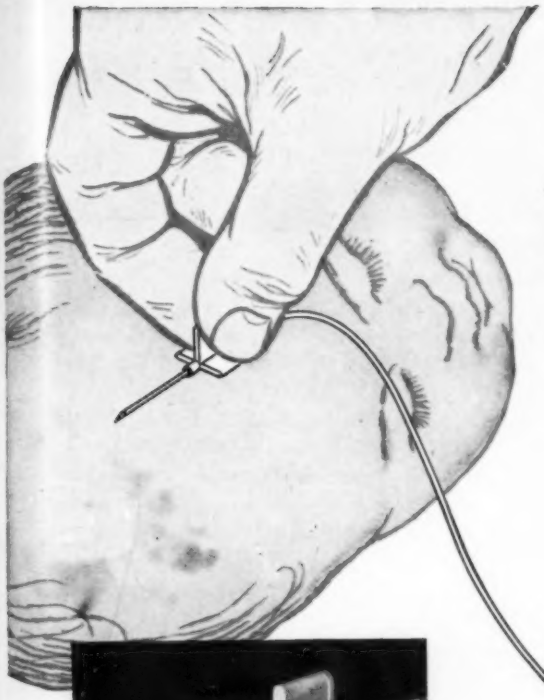
In accepting a hospital insurance program in Canada—and this acceptance is pretty general —it seems to me that society has done something more than just make arrangements whereby the cost of hospital care would be met on an insured basis. In addition to setting up this program for the payment of costs, society has said, in effect, that it must take a greater interest in all aspects of hospital service, in the organization of our hospital pattern, in their relationship to other health services, in their efficiency, and in the amount of productive capacity that we will allocate to these forms of health service. And as the chosen agent to provide leadership, co-ordination and supervision, society has selected its representative—the government.

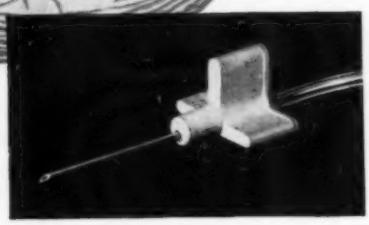
Somehow we get a little emotional when we think of government intervention in our affairs. We tend to forget that government is merely a tool by which our society chooses to get things done. Our ideal is Abraham Lincoln's — "Government of the people, by the people, and for the people." But as I said, our thoughts tend to get a bit fuzzy at this point.

Many, if not most of us, see government as some kind of an ogre who delights in beating us about. Of course, I cannot conceive of anyone thinking in these terms of a certain health department of a province which I am too modest to mention. But come that deadline on April 30 each year when I have to make a financial contribution to another government, I can think of some very unflattering things to say about that government. Or when I employ some young person who I think can't write or spell, I can think of some nasty things about the government's program in education. What I fail to realize is that the young person I hire has a lot more knowledge than I had at the same age. Any of you with young children can testify to this —or haven't you been asked why we should try to land on Mars and not on Venus.

Let me make it quite clear that I am not trying to create the impression that governments or their immediate public servants are perfect or omniscient or above

(concluded on page 90)





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Help the R.C.M.P.–

Watch for these People

The Journal has been asked to co-operate with the Royal Canadian Mounted Police in circulating a description of the undernoted woman and man. If you know their present whereabouts, you are asked to communicate with the nearest detachment of the Royal Canadian Mounted Police.—*Editor.*

Yvonne Conley, with aliases: Yvonne B. Blunt, Yvonne Broome, Starr Burk, Lee Burke, Yvonne Galipeau, Yvonne Hales, Yvonne Mason, June Noble, Doris Walker, Lee Walkers, and others. Description: Age 45, born July 19, 1913, St. Pierre, Manitoba; Height, 4′ 11½″; Weight, 140 pounds; Build, heavy; Hair, brown; Eyes, brown; Complexion, dark; Race, white; Scars and marks, ½″ cut scar on forehead between eyebrows, ½″ cut scar under chin, scar on back of left hand, hysterectomy scar, numerous needle marks on hips; some upper teeth reportedly missing; has had cirrhosis of the liver.

George Edward Cole, with aliases: George E. Cole, George Edward Puckett, George Edward Cole Puckett. Description: Age 31, born March 24, 1927, Philadelphia, Pennsylvania; Height, 6′ 1″; Weight, 160 to 178 pounds; Build, medium; Hair, brown, receding; Eyes, brown; Complexion, medium; Race, white; Nationality, American; Occupations, bus driver, truck driver, typist; Scars and marks, pit scar on outside corner of right eye, small cut scar on inside of left wrist, appendectomy scar, tattoo of small heart and names "Mom" and "Dad" and letters "GP" or "SP" on left forearm, tattoo of eight point star on back of left hand; Remarks, wears full upper denture.

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Coming Conventions

Jan. 19-23—Housekeeping Institute, sponsored by the C.H.A. and A.H.M., Winnipeg, Man.

Jan. 26-30—Housekeeping Institute, sponsored by the C.H.A. and the Saskatchewan Hospital Association, Regina, Sask.

Jan. 28-30—Labour Relations Institute, sponsored by the C.H.A. and the S.H.A., Civic Health Centre, Regina, Sask.

Feb. 5-7—American College of Hospital Administrators, 2nd annual congress on administration, Hotel Sherman, Chicago, Ill.

Mar. 2-4—Institute on Safety and Insurance, sponsored by the American Hospital Association and the Ontario Hospital Association, King Edward Hotel, Toronto, Ont.

Mar. 4-6—Quebec Hospital Association, annual convention, Windsor Hotel, Montreal, Que.

Apr. 6-9—Nurses-Surgeons Joint Meeting, American College of Surgeons in Canada, Montreal, Que.

Apr. 6-9—A.C.S. Section Meeting on Ophthalmologists, Queen Elizabeth Hotel, Montreal, Que.

May 11-13—Canadian Hospital Association, 15th biennial meeting, Queen Elizabeth Hotel, Montreal, Que.

May 30-June 4—Catholic Hospital Association, 44th annual convention, Saint Louis, Missouri.

June 9-12—Health Technicians Sixth International Exhibition-Congress, Exhibition Park, Porte de Versailles, Paris.

June 21-25—Canadian Society of Laboratory Technologists, annual meeting and convention, Palliser Hotel, Calgary, Alta.

June 24-26—Comité des Hôpitaux du Québec, annual convention and commercial and scientific exhibition, Windsor Hotel and Montreal Show Mart Inc., Montreal, Que.

July 20-24—Canadian Medical Association—British Medical Association, joint annual meeting, Edinburgh, Scotland.

B.C.H.I.S.

(concluded from page 72)

they are being denied services for their patients. Nevertheless, I am satisfied that well organized medical staffs who are consulted fully on medical administrative matters agree that it is not possible to have every service in every hospital, and will assume a great measure of responsibility to ensure the utmost in professional care of the patient, control of unnecessary hospitalization, and the safeguarding of hospital funds by constantly reviewing demands for new services and equipment, and studying the use of drugs, and the amount of medical care.

Finally, the patient, while availing himself of the marvellous benefits of coverage under the federal-provincial hospital insurance program, has a grave responsibility to ask only for the care he needs. If he puts pressure on his doctor to keep him in hospital longer, or admit him for something that requires only outpatient services, he is increasing unnecessarily the costs borne by the people of his province and is, in fact, taking money out of his neighbour's pocket. ■

Provincial Notes
(concluded from page 60)

have been completely remodelled and renovated—the new $5,000,000 modern unit will be able to look after 275 patients.

The newborn babies at l'Hôpital Ste-Thérèse in Shawinigan Falls will spend their first few days of life in a nursery equipped with very modern (and very utilitarian) furniture. New units, topped by plastic basin-cribs, contain everything required for babies—diapers, wash basin, et cetera. The plastic cribs on top are light enough to be easily moved. This, combined with the compactness of the units, makes the nurses' jobs easier and the babies' lives more peaceful and pleasant.

New Brunswick

The contract has been awarded for construction of a new wing to the Miramichi Hospital in Newcastle. Architects Ivan Belanger and Cyrille Roy designed the wing, which, when completed, will meet a great need in the community.

Nova Scotia

Recently the Halifax city council was urged to accept the offer of the federal health department to lease the Trachoma Hospital for ten years. The hospital would be used as a home for welfare patients — renovation costs would amount to about $61,000.

Auxiliaries
(concluded from page 70)

room in the children's ward of the new hospital.

Items for the sale were collected in a very methodical way. Work parties were organized by the convenors, and the town was divided into districts with a member in each district offering her home as a collecting depot. Before the sale, members had just one worry. They didn't want to be quite as efficient as they had been in the spring. For then, in a burst of enthusiasm, they sold a volunteer's glasses!

A Shower of Goodies

A fruit and vegetable shower held by the auxiliary of the Tillsonburg District Memorial Hospital, Tillsonburg, Ont., was a great success. In one day, 634 jars of fruit, 90 jars of jams, jellies, honey, et cetera, and a quantity of vegetables were collected. And the members were confident that still more was forthcoming.

TO SERVE HIS CUSTOMERS DEPENDABLY, George needs service, too. King Brothers' Meat Market at 8 McRae Drive, Toronto, is mighty important to hundreds of its neighbours because it supplies their tables with food. Quality is George's big selling point—and he gets a lot of help in making quality decisions from his friend and supplier, Tom Woodward, one of Canada Packers' salesmen. Here they're discussing a side of Maple Leaf beef in George King's cooler.

HOW GEORGE KING KEEPS THE FINEST OF MEATS ON HIS CUSTOMERS' TABLES . . . WITH HELP FROM A GOOD FRIEND

GEORGE KNOWS HIS CUSTOMERS' LIKES, and wide variety is an important one. You can't have a healthy family with appetites that lag. Varied menus perk up appetites. Here, George and Tom discuss an assortment of Canada Packers' products to give George King's customers lots of good ideas!

GEORGE'S FRIEND AT CANADA PACKERS knows quality on the table, too. After a busy day serving his retailer customers, Tom Woodward is ready to light into a hearty meal at home—planned around "CP" products. For he knows they're as good in flavour as they are in quality.

Where your money's worth counts for most... this friendly mark

CANADA PACKERS

PLEDGE OF FINEST QUALITY

is worth keeping in sight

It's worth remembering that our "CP" mark is our pledge to serve you and your customers with foods that will always give them their money's worth—and more, too.

Giving them their money's worth, of course, is simply the business-like way of keeping our customers.

But our "CP" pledge puts us under a greater obligation. This industry is a keystone in Canada's economy. As a leader in it, Canada Packers is in touch, through its suppliers and the people it supplies, with almost every part of Canadian life.

We acknowledge this obligation! We must further it by making fullest use of our resources — technical and scientific — by devoting them to constant improvement of our products — by development of new products to fit special needs.

And by our best service to those who help bring our products to Canadian tables.

Who judges how well we fulfill this obligation? Our customers do. And we are determined to keep them for our friends.

That's why we keep our eyes on our "CP" mark and pledge—and why you'll find it worth keeping in sight, too.

CANADA PACKERS

PLEDGE OF FINEST QUALITY

Catholic Hospital Conference of Saskatchewan

In October of 1958, delegates gathered together for the two-day convention of the Catholic Hospital Conference of Saskatchewan. It was attended by about 75 sisters, representatives from most of the 23 Catholic hospitals operated by nursing sisters in the province. Among those offering greetings to the assembled crowd were His Excellency Bishop Francis J. Klein of Saskatoon; Hon. J. Walter Erb, minister of public health, Regina; C. W. Barton, president, Saskatchewan Hospital Association, Regina; Rev. Father A. L. M. Danis, executive director of the Catholic Hospital Association of Canada, Ottawa; and Dr. D. F. W. Porter, president of the Canadian Hospital Association, Bathurst, N.B.

A resolution passed at the convention contained a demand for recognition of depreciation and interest on capital debt as true operating expenses—necessary if Catholic and other voluntary hospitals are to survive.

A highlight of the convention was an address by the Most Rev. P. F. Pocock, Archbishop of Winnipeg, Man. He spoke on the spiritual responsibilities of nursing sisters, stressing the necessity of looking at patients not as bodies but as souls. The spiritual as well as the physical well-being of patients must be considered, he said. Another interesting speech was given by Rev. W. Wadey, Regina, on "Leadership". Sr. Justina of Normandy, Mo., talked about the "Challenge to our Apostolate of Care". A report on Catholic hospitals and unions was given by Rev. B. V. Megannety, Edmonton.

The new officers elected are: *president*—Sr. Mary Esther, C.S.J., St. Joseph's Hospital, Estevan; *vice-president* — Sr. M. Elizabeth, C.S.M., Mercy Hospital, Regina; *secretary-treasurer*—Sr. M. Noella, C.S.J., St. Joseph's Hospital, Estevan, and *chaplain* — Rev. C. S. Godin, Providence Hospital, Moose Jaw. Sr. Margaret Marie, S.C.I.C., Holy Family Hospital, Regina, is *past president*. ■

Quebec Hospital Association to Hold Convention-Exhibition

The first annual convention-cum-exhibition of the Quebec Hospital Association, which was formed in March 1958, will be held in the Windsor Hotel and the Montreal Show Mart this year from the 4th to the 6th of March. A broad program is being planned, and a substantial representation of hospitals throughout the province of Quebec has already been indicated. Enquiries about the products exhibition part of the convention should be addressed to Quebec Hospital Association, P.O. Box 177, Station H., Montreal, Que.

* * * *

L'Association des Hôpitaux du Québec, fondée en mars 1958, tiendra son premier congrès annuel, en même temps qu'une grande exposition, à l'hôtel Windsor et le Montréal Show Mart, les 4, 5 et 6 mars 1959. Un vaste programme est en voie de préparation, et une large représentation des Hôpitaux du Québec est dès maintenant assurée. Les demandes de renseignements au sujet des produits qui pourront être mis en montre au cours de l'exposition doivent être adressées à l'Association des Hôpitaux du Québec, boîte postale 177, station H, Montréal, Que.

Alberta Convention

(continued from page 54)

tals under the chairmanship of Stewart M. Chapman of Lethbridge.

Reports were received from the seven regional conferences into which the hospitals of the province are divided. It was evident from these reports that there was considerable activity among the conferences, one to four meetings per year being held, while liaison was maintained by having officers of the association in attendance. The Minister and other officers of the Department of Health also attended several conference meetings.

Dr. John B. Neilson of Toronto gave a comprehensive review of the development of the accreditation program as it affected Canadian hospitals, and brought the delegates up-to-date on plans for the inauguration of an all-Canadian program of hospital accreditation commencing January 1st, 1959 (See *Canadian Hospital*, December, 1958). A report on some of the highlights of Canadian Hospital Association activities was presented by the assistant director, Murray Ross.

The report of the Alberta Blue Cross Plan, sponsored by the association, presented by the executive director, Joseph A. Monaghan, clearly indicated that Blue Cross in Alberta is continuing to prosper. Even though the bulk of the hospital services provided in the province now come under the government insurance plan, Blue Cross is providing a greater volume of coverage than ever before. Blue Cross has paid hospital bills totalling nearly ten million dollars since the inception of the plan about ten years ago.

Resolutions

Several periods during the convention were devoted to debating resolutions presented by the resolutions committee under the chairmanship of A. Gladstone Virtue, Q.C., of Lethbridge. Several matters for reference to the government and problems for consideration by the in-coming board of directors came out of the resolutions approved by the delegates.

The government is requested to seek clarification of the status of hospital expenses which are provided under the hospital insurance plan in respect to the amounts deductible from earnings for income tax purposes. The Department of Health is requested to modify its regulations respecting the date

upon which certain returns must be made and to reconsider the basis for recording earned income. The government is urged to give consideration to the inclusion of outpatient services as a benefit under the hospital insurance plan and, in any event, to extend such benefits to persons who are insured as social assistance cases.

The officers and directors of the association are directed to study the possibility of inaugurating courses for training matrons of small hospitals and to consider, with the Department of Health and the University, a recruitment program to support existing courses for training x-ray and laboratory technicians. It was agreed that, upon request, the association would study and evaluate salary schedules proposed by professional organizations and would make recommendations about them to the members. Consideration is to be given to the inauguration of a comprehensive pension plan on a contributory basis.

A count of the voting delegates was necessary in order to determine passage of the resolution calling for alternating the locale of the annual convention between Edmonton and Calgary or another suitable centre. The delegates recorded greetings, and wishes for a speedy recovery from his illness, to Dr. Angus McGugan of Edmonton.

Election of Officers

The following officers and members of the board of directors were elected for the ensuing year: *honorary president*, Honourable J. Donovan Ross, M.D., Minister of Health; *president*, Chief Judge Nelles V. Buchanan, Edmonton; *vice-president*, Sister Mary, Barrhead; *past-president*, S. V. Pryce, Calgary; *directors:* W. Chessor, Lacombe; F. W. Lamb, Lethbridge; H. P. Wright, Calgary; S. M. Chapman, Lethbridge; Sister Alice Gauthier, Edmonton; J. Cramer, Drumheller; J. E. Carlson, Vulcan; Dr. D. R. Easton, Edmonton and elected to the board of trustees for the Blue Cross Plan were: Sister Alice Gauthier, L. R. Adshead, and S. V. Pryce. ■

Colour Under Trees

Masses of spring bulbs at the base of a big tree solve the problem of getting colour in this spot. By the time the tree leaves cast too much shade for growing plants, bulbs will have completed their growth for next year, and will be ready for summer rest.—*Institutions.*

(concluded from page 76)

criticism. I know rather intimately one government organization that is far from perfect and needs, indeed welcomes, constructive criticism all the time. What I want to say is that our society has recognized the growing complexity of its affairs and has chosen its elected representatives to guide its destiny in a more direct way than has been heretofore.

If this development has in fact occurred, then we come to the question of how hospitals and governments are going to work together to meet our common obligation. A great deal of co-operation has been present in the past, and I would submit that there are no real barriers to extended co-operation—provided that certain basic premises are kept in mind.

Both hospitals and government must continually realize that their sole reason for existence is to serve the public. When either of them gets the idea that it is an end unto itself then trouble is just around the corner.

Both hospitals and government must realize that there are certain things that each can do best. I have always been a strong believer in the local autonomy of hospitals. But because I believe that the people in any community are the appropriate persons to run the hospital in that community does not mean that I think they have the available information to see properly their hospital's rôle in the provincial or national picture. Here they may need direction, guidance, and indeed, supervision from a larger central agency.

In spite of my belief that there are certain things which can best be done by hospitals and other things which can best be done by government, I would emphasize that everyone must recognize that knowledge and judgment about any topic are not exclusively the property of any one group.

This brings me to my third point. Continuous consultation and discussion must go on between hospitals (singly or collectively) and governments. This consultation has two purposes—firstly, to serve as a medium for mutual education and for disseminating information; and secondly, to seek the appropriate decisions based on the information available.

I am an advocate of strong,

energetic hospital associations which can speak for hospitals collectively and which can do much to carry on educational programs for their member hospitals. On the other hand, I believe that governments can provide much service to hospitals with consultation and advice. I am not even suggesting that hospitals and governments will see eye to eye about every problem. There is nothing wrong with honest differences of opinion. In other words, there must be a mutual acknowledgement that nobody has all the answers.

If we accept these three premises, there is no reason why we should not be able to develop a smoothly functioning hospital program with the two groups making individual and collective contributions. This will, in the end, serve the best interests of our people in the best way possible. Perhaps even a future generation will be able to look back and say—"Those must have been interesting pioneering days when they had hospitals and doctors and nurses. I wonder what sort of problems they had." ■

In Alberta

(concluded from page 38)

lems of capital costs, it is quite logical that the federal government should adopt a broader basis for determining eligibility for construction grants. This would enable the federal government to share capital costs in the manner outlined.

Nursing Homes

The part played by senior governments is influenced somewhat by the fact that they can get results which would be difficult, if not impossible, for any other smaller, less centralized group. For example, let us look at nursing home care. Private organizations have attempted to meet the problem, but since it affects the whole of the population, the results attained by the individual groups have not been satisfactorily meeting the total need.

Recognizing the necessity of having nursing home beds available so that active treatment beds may be used to maximum efficiency, and recognizing too, the difficulty private groups have in providing the necessary nursing home care, the provincial government intends to introduce legislation during its next session to cover this need. I believe that this is a step in the right direction, since as I have previously stated, the senior government will be able to give leadership where private enterprise has found it difficult or impossible. I do not wish to imply that certain private organizations have not done an outstanding job in establishing this type of care. However, it would appear from the unsatisfied demand for nursing home care that this is a service where a senior government, in whole or in part, can provide the answer. ■

Hospital consultants

Consulting engineers

Leisure and Productivity

"The conspicuous preoccupation of the West with leisure, with ever lighter work and shorter hours, is singularly untimely. In this process, productivity per capita is in danger of falling, at the very time when the costs of production are rising. And as costs of production rise, the power to compete declines. And when the power to compete declines, unemployment must then rise."—*The Montreal Gazette.*

Classified Advertising

Advertisements for insertion should be mailed to Canadian Hospital, 57 Bloor Street West, Toronto 5, Ontario. Rates for classified advertisements are as follows:

$3.75 per column inch or fraction thereof, minimum charge $3.75. Display advertisements, set in a box, may be requested on advertisements of 2 inches or larger at no additional charge, ¼ page display advertisement—$25.00. Advertisements must be received by the first of the month to appear in that month's issue.

Qualified Dietitians

Are needed to complete the staff of six dietitians at the Royal Jubilee Hospital in Victoria, B.C. Excellent personnel policies, 4 weeks' vacation, pension and medical plans, starting salary $280.00. Interesting work in a stimulating environment; new wing planned for future. For details write Miss Mary E. O'Brian, Director of Dietetics.

Position Wanted

Administrator with American qualifications and training wishes to return to eastern or western Canada. Desires position with 100-150 bed hospital as Administrator, or Assistant Administrator of a larger facility. Past five years experience in 100 bed hospital. References and resume will be submitted promptly upon request. Please reply to Box 102G, The Canadian Hospital, 57 Bloor Street West, Toronto 5, Ontario.

Director of Nursing

For approved J.C.A.H. 108-bed hospital planning a 100-bed addition. No School of Nursing at present. Degree in nursing administration preferred but not essential. Successful experience in nursing education would be an advantage. Salary open. Personnel policies include 40-hour week, pension plan, sick leave, 4 weeks' vacation after one year of service, 8 statutory holidays. Apply: Administrator, North Bay Civic Hospital, North Bay, Ontario.

Director of Nursing Required

For Cobourg District General Hospital, Cobourg, Ontario, on Lake Ontario, 70 miles east of Toronto. 115 beds. Excellent personnel policies, including 40-hour week. Applications confidential. Apply to N. R. Dearlove, Administrator.

Central Supply Supervisor

Required immediately for a completely new department in a 115-bed general hospital near Lake Ontario and 70 miles east of Toronto. Experienced supervisor needed. Apply to N. R. Dearlove, Administrator, Cobourg District General Hospital, Cobourg, Ontario.

Administrative Personnel Placement Service

Mary A. Johnson Associates welcomes inquiries from Hospital Trustee and Administrative and Department Head Level Personnel for Hospital and Medical Group positions.

Dr. Johnson is trained and experienced in Hospital administration as well as Personnel Management and is available for Consultation of Personnel needs.

Our files contain many well qualified personnel as well as interesting openings.

We pride ourselves on careful screening of all clients and thorough investigation of openings. Our aim: to match the applicant and the specific position.

MARY A. JOHNSON ASSOCIATES

11 West 42 Street, New York 36, N.Y.

Mary A. Johnson, Ph.D., Director

Director of Nursing Wanted

For a 180-bed hospital with a school of nursing. Applicant with University degree and or post-graduate course preferred. Salary commensurate with experience and qualifications, position available May 1959. Apply—Secretary, Board of Directors, Victoria Union Hospital, Prince Albert, Saskatchewan.

Dietitian Required

Immediately for 250 bed new hospital, with School of Nursing. Pleasant working conditions. Salary commensurate with training and experience.

Apply to: Miss N. Flanagan, Administrator-Secretary, Municipal Hospital, MEDICINE HAT, Alberta.

ASSISTANT DIETITIAN REQUIRED

Please apply stating
Experience and Qualifications
to
The Superintendent
Peterborough Civic Hospital
Peterborough, Ontario

Position Wanted

Toronto graduate, NACHA, 3½ years experience, currently employed, desires to relocate as administrator of smaller or assistant of large hospital. Address: The Canadian Hospital, Box 1203R, 57 Bloor Street West, Toronto 5.

CANADA'S CHEMICAL VALLEY

Sarnia, Ontario

Assistant Medical Record Librarian

and

Medical Secretary

Required for modern, fully approved (J. C. A. H.) 300-bed well equipped hospital.

This progressive, industrial city of 50,000 is growing; it is a resort area located on the shores of Lake Huron and the St. Clair River.

Qualifications for Assistant Librarian include R.R.L.

Qualifications for Medical Secretary are experience in secretarial duties, and medical terminology.

Excellent personnel policies, 5-day week.

For further details and literature concerning the positions and Sarnia, write to

Personnel Director

SARNIA GENERAL HOSPITAL

Sarnia, Ontario

LEUKOPLAST.....

THE IDEAL ADHESIVE TAPE

WATER-REPELLENT
WHITE OR FLESH
LIGHTWEIGHT TEXTURE
EXTRA STRONG
LONG STORAGE LIFE
RESISTS TEMPERATURE CHANGE
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ORIGINAL Beiersdorf PRODUCT

SYMBOL OF QUALITY

P.R. Institute

A public relations institute sponsored by the Ontario Hospital Association was held at the Hotel London and the Victoria Hospital in London, Ontario, on September 30 and October 1. Some 38 hospitals were represented by 80 hospital delegates.

The two-day institute, began with a talk by Mrs. Charles McLean, a past president of the association, on "Public Relations — An Institutional Responsibility". The next speaker, S. W. Martin, executive secretary-treasurer of the O.H.A., spoke on "A New Era—A New Story". He was followed by G. S. Roberts, director of public relations for the association, who discussed the subject of "Communications". The last speaker on the agenda was H. M. Savage, press relations consultant for the O.H.A., whose topic was "What is News?"

In the evening representatives from both the hospitals and the news media took part in a lively panel discussion, "What's Your Beef", which dealt with hospital-press relations.

The second day got under way with a talk on "Employee Relations" by E. R. Willcocks, superintendent, Toronto East General and Orthopaedic Hospital. Reverend James Ferguson, Barrie, now president of the O.H.A., spoke on "Fund Raising For Expansion". He was followed by H. G. Dillon, administrative assistant of the association, who told of the various ways in which the association could be of assistance to member hospitals.

The afternoon program included a discussion of "The Trustee's Rôle" by W. M. Gray, a past president of the O.H.A., and a report on "The Rôle of the Women's Hospital Auxiliaries" by Mrs. A. H. Lyon, director of public relations for the women's hospital auxiliaries for the province of Ontario. The session concluded with a new public relations film, "The Patient is a Person."

Home Care Plan in Toronto

Dr. L. A. Pequegnat, retired medical officer of health for the city of Toronto, Ont., is organizing a pilot home care service in one of that city's public health divisions. Other cities have pioneered on the home care treatment but Toronto's system is unique since it centres on the family doctor. It is the doctor who decides whether or not his patient can be treated as well at home as in the hospital, and it is he who will request what he thinks necessary in equipment or services. The purpose of the plan is to shorten some patients' hospital stay, and to keep others from the hospital entirely. It is not a substitute for hospital care but a method of providing that patients, including the chronically ill, have continuous care and maximum rehabilitation in familiar surroundings. By providing home facilities, the home care service hopes both to free more hospital beds and to provide better care for homebound patients.

Dr. Pequegnat will co-ordinate the services of nurses, homemakers, physio- and occupational therapists, the Red Cross and other agencies. Payment will be arranged directly between the patient and the agencies. — *Canadian Journal of Public Health.*

Health Problems of the Aged

The Joint Council for the Health Care of the Aged plans to sponsor a national conference on the health problems of the aged, to be held in the spring of this year. This conference is to provide a basis for more effective joint planning by those who are the principal purveyors of health care for the aged. The Joint Council, formed only last April, is sponsored by the American Dental Association, the American Hospital Association, the American Medical Association, and the American Nursing Home Association.

A NEW UMBILICAL CORD CLAMP.* An important feature is that the size of the locking device is not predetermined. Once the clamp is applied to the cord it may be tightened by putting a little more arch in the clamp. Its overall length is one and a half inches, and the width of the clamp is five-sixteenths of an inch. The lightness of the material is another distinct advantage. The ease of application and sturdiness of its construction make it a very satisfactory instrument. After ascertaining the absence of any abnormality of the cord, the clamp is applied and the cord distal to the clamp is "milked" away for about an inch where a forcep is applied. The cord is then cut. This way there is no spattering of the cord blood which so often is under considerable pressure. After applying an antiseptic to the open end, a piece of gauze with a hole in the center is slipped over the clamp and another square piece of gauze put over the clamp in the conventional manner.—JOHN A. HAUGEN, M.D., Minneapolis, Minn.

. . . Across the Desk

News Released by Hospital Supply Houses

By C.A.E.

New Kodak Copier Allows Copying of Larger Originals

A new deluxe model Verifax Copier, which can copy anything from a business card to an outside 10- by 16-inch inventory form, has been announced by Kodak.

Designated as the Verifax Viscount Copier, the new office copying unit is expected to prove particularly useful to those requiring copies of larger originals. For example, the new Viscount can copy out-size legal documents, accounting forms, 10- by 16-inch financial forms and standard letter-size originals, with equal ease.

The Verifax Copier, legal size, has an improved paper feed assembly, a new trimmer guide assembly for 10-inch paper, and makes the same photo-exact copies characteristic of the Verifax copying method.

In addition, the new Copier embodies an "automatic" timer which compensates for changes in electrical voltage.

With the addition of the new Viscount, there are now four copiers in the Verifax line: the Verifax Bantam Copier ($110.00); the Verifax Signet Copier ($165.00); the Verifax Copier, Letter Size ($270.00); the Verifax Viscount Copier ($465.00). The Viscount makes the same multiple, photo-exact copies that typify all four models in the Verifax Copier line. Up to five copies of any typed, drawn, written, or printed original may be made on the Verifax Viscount Copier at a materials cost of about 3½ cents per copy. Capable of making intermediates or masters on Verifax translucent copy paper for use in diazo-type printers, the Viscount is also adaptable for use with the Verifax method of producing offset masters for office-type duplicators.

Complete information on the new Copier may be obtained from Canadian Kodak Sales Limited, Toronto 9, Ontario.

Clay-Adams High Speed Centrifuge

A new, high-speed centrifuge developed by Clay-Adams, Inc., New York, is said to embody every desired advantage in a unit specially designed for micro-chemistry determinations.

The Adams Micro-Chemistry Centrifuge utilizes the angle principle for quick, efficient centrifugation at 13,500 rpm (15,500 rcf), and accommodates both glass and disposable plastic tubes of 1 ml., 0.5 ml. and 0.25 ml. sizes.

Versatility of the machine in handling tubes of three different sizes is made possible by two sets of eight each specially designed polyethylene adapters, furnished with each centrifuge.

It runs quietly, owing to precision machining and perfect balance of the eight-place head, and unique shock-mounting of housing, motor and head. Separate ventilation systems for head and motor chambers prevent overheating of the instrument or specimens, and also play a part in reducing the sound of the unit to a minimum.

A dial timer is set for one to thirty minutes, after which an automatic brake gradually stops the head without any action on the part of the technician or operator. Stops in 60 seconds, gradually, without disturbing sediment.

The instrument is available through surgical and scientific dealers.

Onan Adds A New Distributor in Canada

The firm of Simson-Maxwell Alberta Limited, Edmonton, Alberta, is a new distributor for D. W. Onan & Sons, Inc., Minneapolis, Minnesota.

In addition to its regular lines of merchandise, the firm will now handle the complete line of Onan gasoline and diesel electric generating plants, air cooled engines and separate generators.

The firm will carry in stock a selective range of these completely self-contained generating sets up to and including 10,000-watt capacity units. Larger sizes (up to 150,000 watts, gasoline-driven; 200,000-watts, diesel driven) are available according to customer requirements. This entire line of

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Across the Desk

(continued from page 96)

equipment is backed by a substantial stock of Onan replacement parts, and facilities are available for the service and repair of Onan products.

Lac-Mac Catalogue of Hospital Apparel

Lac-Mac Limited of London has announced the further revision of its well-known catalogue. Over 100 textile garments, binders, drapes and other items are described and illustrated in detail. It represents, in picture and word, the result of almost 40 years experience and development by this Canadian company, using Canadian materials for the requirements of its special field, Canada's hospitals.

Mailing of the catalogue and up-to-date printed price list has been recently completed. Further copies are available on request.

Plasmanate is New Cutter Plasma Protein Fraction

Cutter Laboratories, Berkeley, California, has developed a new plasma-like blood fraction product which can be heat treated against the serum hepatitis virus, yet remain a stable, clear fluid. Cutter's product, which carries the trade name Plasmanate and the generic name Plasma Protein Fraction 5% (Human) Heat Treated, is the result of five years of laboratory research and two years of clinical work.

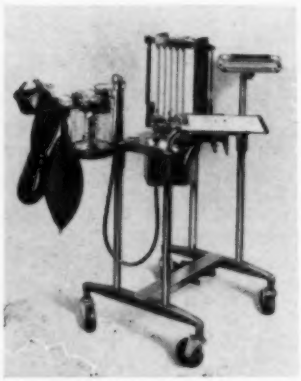
Government agencies and the pharmaceutical industry have been working for years to find a human origin shock unit which does not have the serum hepatitis virus danger of plasma and the high cost of human serum albumin. The yield of Plasmanate in shock units from the starting raw material, human whole blood, is about halfway between human serum albumin and plasma.

Cutter will supply Plasmanate to physicians and hospitals in a ready-to-use kit containing 250 cc. of Plasmanate, a disposable infusion set with needle, and an air inletting needle.

Ohio Chemical Three-Gas Stand Kinet-O-Meter

A new three-gas stand "Verni-Trol" Kinet-o-meter® is now available from Ohio Chemical Canada Limited, Toronto 2. In this unit both the "Verni-Trol" vaporizer and long-scale flowmeters are positioned in the centre of the top deck. Four vertical posts support the chassis. In addition to making this Kinet-o-meter extremely stable, the posts make the unit versatile with respect to mounting of the absorber, vaporizers and other accessory items. Mounted accessories can be easily changed or repositioned on any one of the four posts.

Five long-scale, easy-to-read flowmeters provide a high degree of accuracy. Large visible floats are easily read against a brilliant colour background identifying the gases.



Gas delivered from the flowmeter may be easily switched from the absorber to an accessory vaporizer by moving a 15 mm. slip-joint connector on the end of the supply tubing. The "Verni-Trol" vaporizer produces consistantly high concentrations of ether vapor over long periods of time. A circuit control valve is located on top of the unit and directly in front of the flowmeter. When the valve is turned to "O_2 Flush," the ether is shut off and the flow of oxygen is at the rate of 60 l. p.m.

For additional information please write to Ohio Chemical Canada Limited and request catalogue section No. 4818.

Clarke Wet-Dry Vacuum Cleaner

Clarke's Model 620 Wet-Dry Vacuum cleaner is one of seven models of a completely new line of wet-dry vacuum cleaners recently introduced by Clarke, which features many innovations in vacuum cleaner design. It is designed for picking up dirt, dust and liquids of all kinds and "cleans everything from floor to ceiling, even furnace boilers", according to Clarke.

The vacuum cleaner is used primarily by maintenance staffs in cleaning such buildings as hospitals, schools and office buildings.

The Clarke line of industrial vacuum cleaners and floor machines is exclusively distributed in Canada by G. H. Wood and Company Limited, who operate branches from coast to coast.

Announcing A New S.K.F. Specialty

A new S.K.F. product is now available for the management of mild to moderate emotional disorders and for the control of nausea and vomiting from a variety of causes.

"Stelazine" (Trifluoperazine, S. K.F.), a new low-dose tranquilizer/antiemetic with inherent long-lasting activity.

Available for oral administration in three dosage strengths: 1 mg., 2 mg. and 5 mg. tablets in bottles of 50 and 500. For parenteral administration, "Stelazine" is available in 10 cc. Multiple-Dose vials (2 mg./cc.) as individual units, and 1 cc. Ampuls (1 mg./cc.) in boxes of six.

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Across the Desk

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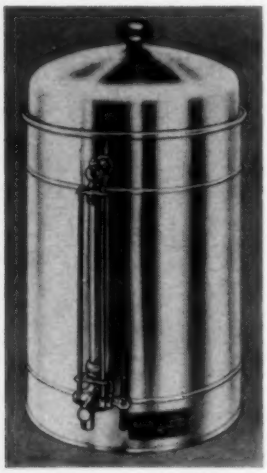
Full particulars available from Smith, Kline and French, 300 Laurentian Boulevard, Montreal 9.

Shampaine Low Priced Water Sterilizer

The Shampaine Electric Company of New Rochelle, New York, has just announced the development of a new low priced water sterilizer, 5 gallon capacity, in all stainless steel construction.



The sterilizer is fitted with Robert Shaw thermostat control and with manual recessing feature. It can also be used for keeping sterile water at any desired temperature. Unit is complete with 1500 watt heating elements, thermostat, pilot light, "on off" switch, cord and plug. The Shampaine Electric catalogue number is SE-305.

Hobart Steakmaster Deluxe Tenderizer

The Model 401 Steakmaster will tenderize a whole flank steak or produce an endless variety of quick-cooking, individual portion steaks from many different combinations of beef, veal, lamb, pork or turkey —even knitting in suet, onions, cheese, parsley or pork fat if desired.

Steakmaster's exclusive "draw-cut knit-knife" stainless steel blades cut meat (no punching) while, at the same time, knit it so firmly together it cooks as one solid steak. The clear plastic cover enables the operator to see the steak during every second it is in the machine. Other important features are the practicability of the stainless steel working parts of the distinctive lift-out tenderizing unit.

Power is supplied by a 1/3 H.P. motor, furnished in single phase, 50 or 60 cycle alternating current of 115 volt direct current. Finish is white enamel with chrome trim, and standard equipment includes a specially designed blade resharpening file, a cleaning-fork, cord and plug. Further information may be obtained from The Hobart Manufacturing Company Limited, Toronto 2.

Exide Publishes Manual On Storage Battery Use

A detailed technical manual on the use, characteristics and care of stationary storage batteries in switchgear control and emergency light and power control, has recently been published by the Exide Industrial Division of The Electric Storage Battery Company.

The 24-page manual, Bulletin 210, has the first reports on new engineering studies of the effect of temperature variance on battery capacity; battery types and selection; discharge ratings and physical characteristics; charging and points on battery care and proper maintenance.

Stationary battery applications covered in the manual include momentary current supply for tripping and closing switchgear; continuous loads for indicating lamps; holding coils for relays; supervisory control equipment and other control devices; and emergency light and power. Algebraic quotations to aid in size and load selection are provided.

The Bulletin also explains how to select the proper size charged by formula and example. Instructions are given for preparing a battery for operation and for giving freshening, floating and equalizing charges.

Copies of Bulletin 210 can be obtained from Exide Industrial Division, The Electric Storage Battery Company (Canada) Limited, Toronto.

Garland-Blodgett's New Line of Electric Ranges

Garland-Blodgett Limited are introducing a complete new line of electric commercial cooking equipment. This new and most advanced line of electric ranges was designed and engineered in Canada. They are produced at Garland's Toronto plant, and meet specific needs of every Canadian commercial cooking establishment. They are C.S.A. approved. Garland Blodgett is justly proud of this extensive line, which offers greater efficiency and utility than ever before.

In keeping with Garland's high standards of construction design, these new ranges incorporate many unique features. All models are heavy duty units, for fully dependable service.

Garland offers a choice of heavy duty range with oven, range with warming oven, range with storage compartment or modular top. There is also a choice of ten cooking top arrangements.

Many quality construction features, including automatic thermostat control, pilot light and sturdy insulation, make for reliable performance and easy maintenance. All models will be in full production and available to Garland dealers early in January.

Full details may be obtained from Garland-Blodgett Limited, Toronto 14.

Floor Covering Offers "Safety in Silence"

Silent safety for hospitals and other institutions is available in a new resilient floor covering announced by Minnesota Mining and Manufacturing of Canada Limited, London, Ontario.

Called "Scotch-Tred" Brand Resilient Non-slip Floor Covering, the material has the additional advantages of being spark-proof, flame resistant, long-wearing and resistant to most chemicals, paints and solvents.

The material is flexible enough to be used on stairs in a continuous strip yet durable enough to give years of service in busy lobbies or reception rooms. Wherever people are in danger of slipping and falling on walks or in corridors; on stairs and ladders; in locker rooms, showers and bathtubs, in the kitchen, at the maintenance bench or in the laboratory, the material can be applied in minutes and is ready for immediate

(concluded on page 101)

Across the Desk
(concluded from page 100)

use. The same resiliency that provides traction makes the material comfortable and silent to walk on, a factor in fatigue reduction. To apply: simply remove the protective back liner; press to a clean dry surface.

Made with a dimensionally stable plastic film backing, waterproof adhesive and a bonded-particle surface, the material is light (2½ ounces per square foot) and thin (45-50 mils).

Newly Developed Traction Shoe

A new development to provide comfort in traction, the Ridgeway traction shoe, eliminates the need for tape and the possibility of tape infection or irritation. The shoe permits traction at home or while traveling.

The Ridgeway, the only traction shoe with hinged sole, gives the patient natural walking privileges and permits full bathroom use and hot baths.

Ideal when traction is required only a few hours daily, the Ridgeway traction shoe gives the patient uniform and constant pull on foot and limb—correct pull where most needed.

Replaceable adhesive inner soles give the equivalent of a new pair of traction shoes for each new patient. Easily washed, sterilized, or autoclaved, the shoe features white duck tops, waterproof flexible plywood soles, replaceable adhesive insoles, rust-resistant metal parts, rubber heels and toes, plastic foam lining over pressure areas, and hinged sole to allow ambulation to patient.

Designed for rapid connection and removal of weights, the Ridgeway has been successfully used and endorsed by armed forces, university and veterans hospitals.

For more complete information, write Torque, Inc., Columbus, Ohio.

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